

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6443

County

Balto.

Village or City

Highlandtown

No.

3409

W. Pleasant St.

Ward)

Registration Dist. No.

41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles B. Adams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

6 DATE OF BIRTH

March

8

1871

(Month)

(Day)

(Year)

7 AGE

43

3

25

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore, Md

10 NAME OF FATHER

Samuel S. Adams

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Caroline V. Holt

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Sackett

(Address)

3409 W. Pleasant Ave

15

Filed

July 5, 1914

W. E. McClanahan

REGISTERED

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

7

3

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to

191

that I last saw h. alive on 191

and that death occurred on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(Duration) yrs. mos. ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

A. S. Warner, M. D.

7-4

1914 (Address) Coroner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

July 5, 1914

20 UNDERTAKER

ADDRESS

Zirkler + Zirkler

3204 O'Donnell

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 7 1914

BUREAU, U. S.

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1 PLACE OF DEATH

6444

County

Baltimore

Village or City

Catonsville

(No.

Winters Ave

St.;

Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Jerry Adams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Cald

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Unk Unk, Unk

(Month)

(Day)

(Year)

7 AGE

53

yrs.

0

mos.

0

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Howard Co

PARENTS

10 NAME OF FATHER

Edward Adams

11 BIRTHPLACE OF FATHER
(State or country)

Howard Co

12 MAIDEN NAME OF MOTHER

Unk

13 BIRTHPLACE OF MOTHER
(State or country)

Unk

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Matthews

(Address)

Catonsville Md

15

Filed

July 7, 1914 Marshall B Wirt

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 6 or 7, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191, to

, 191

that I last saw h alive on , 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Adams went to bed in his usual health and his sister went to call him the next morning & found him dead (Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

Wm S. Hoffman Coroner, M. D.

July 7, 1914 (Address) Catonsville Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Star

July 10, 1914

20 UNDERTAKER

ADDRESS

Ed W Pye

Catonsville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

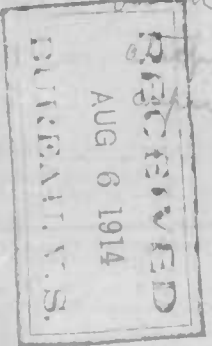
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Idamtion," "Maras-mus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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Peter 187.



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1 PLACE OF DEATH 6445

County

Baltimore

Village or City

Seatonsville

(No.

Spring Grove S. H.

St.

Ward)

Registration Dist. No. 80

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Nichelm Altenburg

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Aug 29th 1840

(Month)

(Day)

(Year)

7 AGE

74 yrs. 10 mos. 10 ds.

If LESS than 1 day, ... hrs. OR ... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Restaurant Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Germany

PARENTS

10 NAME OF FATHER

unk

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

unk

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Bessie Burman

(Address)

5185 Caroline St. City

15

Filed

July 23 1914 Marshall B. Bost.

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 23rd 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, that I attended deceased from

Aug 29th 1913 to July 23rd 1914

that I last saw him alive on

July 23rd 1914

and that death occurred on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration)

yrs. 3 mos. 3 ds.

Contributory (Secondary)

Acute Dementia

(Duration)

2 yrs. 2 mos. 2 ds.

(Signed)

A. Percy Wade

M. D.

July 23, 1914 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs. 11 mos. 25 ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

Balto. Md.

19 PLACE OF BURIAL OR REMOVAL

Schwartz Cem.

DATE OF BURIAL

July 25th 1914

20 UNDERTAKER

John P. Gorman

ADDRESS

Bank Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 6 1914

BUREAU, U. S.

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¹ PLACE OF DEATH 6446
County Balto

Village or City near Uppered (No. _____ St.; _____ Ward)

² FULL NAME Sarah E. Annacost

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 34

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Female ⁴ COLOR OR RACE White ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

⁶ DATE OF BIRTH Dec — 1839
(Month) (Day) (Year)

⁷ AGE 74 yrs. 7 mos. — ds. It LESS than 1 day, _____ hrs. OR _____ min. ?

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

⁹ BIRTHPLACE (State or country) Maryland

PARENTS
¹⁰ NAME OF FATHER Zachariah Ebaugh
¹¹ BIRTHPLACE OF FATHER (State or country) Maryland
¹² MAIDEN NAME OF MOTHER Elizabeth Annacost
¹³ BIRTHPLACE OF MOTHER (State or country) Maryland

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edw. C. Tipton
(Address) Hampstead, Md.

¹⁵ Filed July 17, 1914 E. E. Finkle M. D.
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH 7 16, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from June 25th, 1914, to July 15th, 1914, that I last saw her alive on July 15th, 1914.

and that death occurred on the date stated above, at 9.30 a.m.
The CAUSE OF DEATH* was as follows:

Leukemia, Nephritis Bronchitis

(Duration) 2 yrs. 0 mos. 0 ds.

Contributory Infirmities of age, apoplexy
Secondary

(Duration) 1 yrs. _____ mos. _____ ds.

(Signed) D. W. Reah, M. D.

7-16, 1914 (Address) Hampstead, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL Grace Church DATE OF BURIAL July 18, 1914

²⁰ UNDERTAKER C. Tipton & Son ADDRESS Hampstead, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

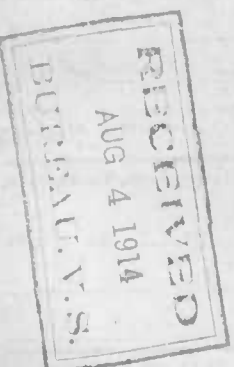
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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

6447

County

Baltimore

Village or City

Wilhelm Park

(No.)

St.

Ward)

Registration Dist. No.

42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Sophie Arnold

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

May

21

1873

(Month)

(Day)

(Year)

7 AGE

41

yrs.

mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE

(State or country)

Baltimore

PARENTS

10 NAME OF FATHER

Jacob G. Harg

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Barbara Krum

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred G. Harg

(Address)

Wilhelm Park

15

Filed

July 25, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

24

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 24, 1914, to July 24, 1914,

that I last saw him alive on July 24, 1914,

and that death occurred on the date stated above, at 7:20 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast
General metastasis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Geo. A. Shewhart, M. D.

July 25, 1914 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Wilhelm Park

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sancton Park

July 27, 1914

20 UNDERTAKER

ADDRESS

L. B. M. report

2238 Indirich

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

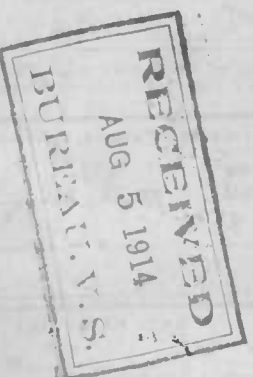
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or NOMINAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Balto

Village or City Highlandtown (No. 113 Fifth)

2 FULL NAME Earl Samuel Arig

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 28 Oct 1913
(Month) (Day) (Year)

7 AGE 8 yrs. 21 mos. 21 ds. If LESS than 1 day... hrs. OR... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) 113 So Fifth

10 NAME OF FATHER Samuel Young

11 BIRTHPLACE OF FATHER (State or country) Balto Co.

12 MAIDEN NAME OF MOTHER Margaret Arig

13 BIRTHPLACE OF MOTHER (State or country) Balto Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Fredricka Arig

(Address) 113 Fifth St.

15 Filed July 24, 1914 W. C. McCann

REGISTERED

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 23, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1914 to July 23, 1914
that I last saw him alive on July 22, 1914

and that death occurred on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Convulsion
+ Exhaustion

(Duration) X yrs. V mos. 1 ds.

Contributory (Secondary) Cholera Infantum

(Duration) X yrs. X mos. 3 ds.

(Signed) Jas. L. Quinn M. D.

July 23, 1914 (Address) 247 So Third

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL McBarnet DATE OF BURIAL July 24, 1914

20 UNDERTAKER Philip Henry ADDRESS 2016 Orleans St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6449

County BaltoVillage or City Highland (No. 430 S 3rd) St.; Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lewis Backer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE w 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) WIDOWED

6 DATE OF BIRTH 7 1 1914
(Month) (Day) (Year)

7 AGE _____ If LESS than 1 day, _____ hrs. _____ yrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER George Backer

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mabel Bathe

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Backer(Address) 430 S 3rd

15 Filed July 17 1914 U.S. No. 1

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 1 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw him _____ alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Cyanosis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. Manger, M. D.7-1-, 1914 (Address) Cecilia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sacred Heart Am. DATE OF BURIAL July 1, 1914

20 UNDERTAKER Lily W. Zink ADDRESS 403 & 100th St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

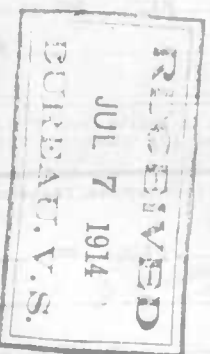
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> <u>6450</u> <u>113</u> | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Glyndon</u> (No. <u>MD</u>) | | Registration Dist. No. <u>33</u> | |
| 2 FULL NAME <u>George W. Bailey</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u> | |
| 6 DATE OF BIRTH <u>Mar 7</u> , 18 <u>85</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>56</u> yrs. <u>4</u> mos. <u>19</u> ds. If LESS than 1 day,.....hrs. OR.....min.? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) <u>Harford Co Md</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>George Bailey</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Harford Co Md</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Elizabeth Spenser</u> | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Harford Co Md</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Catharine W. Bailey</u> (Address) <u>Harvilegians Md</u> | | | |
| 15 Filed <u>July 27</u> , 191 <u>4</u> <u>J. F. Elmer</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>July 26</u> , 191 <u>4</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Mr</u> , 191 <u>3</u> , to <u>July 26</u> , 191 <u>4</u> , that I last saw him alive on <u>July 24</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>9 A</u> m. The CAUSE OF DEATH* was as follows: <u>Cerebral Hemorrhage</u> (Duration) <u>2</u> yrs. <u>0</u> mos. <u>0</u> ds. Contributory <u>Slavering</u> Secondary (Duration) <u>2</u> yrs. <u>0</u> mos. <u>0</u> ds. (Signed) <u>J. F. Elmer</u> , M. D. <u>July 27</u> , 191 <u>4</u> (Address) <u>Glyndon</u> | | | |
| *State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____ | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Rock Run Cemetery</u> | | DATE OF BURIAL <u>July 28</u> , 191 <u>4</u> | |
| 20 UNDERTAKER <u>Harford Co</u> ADDRESS <u>J. F. Elmer</u> <u>Rock Run</u> | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

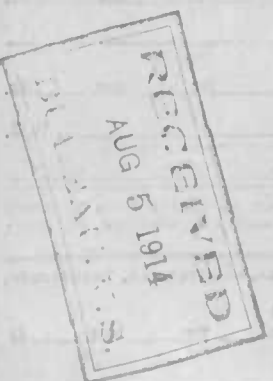
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary, 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Baltimore 6451

(91)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 30Village or City Catonsville (No. Ingliside Ave St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Helen Elizabeth Baker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH June 10, 1911
(Month) (Day) (Year)

7 AGE 3 yrs. 1 mos. — ds. OR — min. ?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Catonsville Md

PARENTS
10 NAME OF FATHER Henry J Baker
11 BIRTHPLACE OF FATHER (State or country) Sykesville Md
12 MAIDEN NAME OF MOTHER Ida F Holtzner
13 BIRTHPLACE OF MOTHER (State or country) Howard Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry J Baker(Address) Catonsville Md

15 Filed July 15, 1914 Marshall B West
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 15, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from —, 191—, to —, 191—.

that I last saw him — alive on —, 191—.and that death occurred on the date stated above, at 5-a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(Duration) 5 mos. — ds.Contributory
Secondary(Duration) — yrs. — mos. — ds.

(Signed) Wm S Hoffman (Address) Catonsville Md
July 15, 1914 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Peter Cmn July 7, 1914

20 UNDERTAKER ADDRESS
Easton Son Ellicott City

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

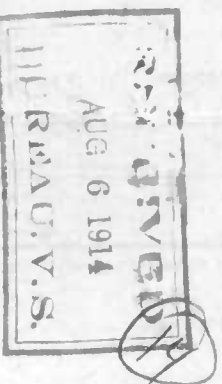
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scuffle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Baltimore

6452

(104)

Thos. Wilson, Sanitarium

Registration Dist. No. 31

Village or City

(No. 2nd)

Thos. Wilson, 2nd

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lizzie Balska

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

Unknown

7 AGE

4 yrs.

mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9 BIRTHPLACE (State or country)

Baltimore, Md.

PARENTS

10 NAME OF FATHER

Peter Balska

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John K. Wilson

(Address)

Baltimore, Md.

15

Filed

, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 5th, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

1914, to

1914

that I last saw him alive on

1914

and that death occurred on the date stated above, at

m.

The CAUSE OF DEATH* was as follows:

Gastro Intestinal Intoxication

(Duration) yrs. mos. 28 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

John K. Wilson

, M. D.

July 5, 1914 (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, At Home

If not at place of death? Baltimore

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Unknown

, 1914

20 UNDERTAKER

ADDRESS

Unknown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

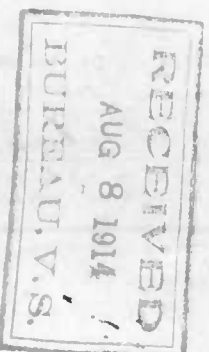
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never, return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Turner (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Genital," "Scirrh," etc.), "Erysipelas," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH
County Baltimore

Village or City mt Hope Retreat (No. 64) St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Andrew J. Baudell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Dont Know
(Month) (Day) (Year)

7 AGE 65 yrs. 0 mos. 0 ds. OR 1 LESS than 1 day, 0 hrs. OR 0 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Dont Know

9 BIRTHPLACE

(State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Andrew J. Baudell
Dont Know

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ann M. Chandler

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Records of mt Hope Retreat

(Address) mt Hope Md.

15 Filed July 7, 1914 Wm. D. Grooms
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 7th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1914, to July 8th, 1914,

that I last saw him alive on July 8th, 1914

and that death occurred on the date stated above, at abt 1 P. m.

The CAUSE OF DEATH* was as follows:

Senile Mania -

abt (Duration) 0 yrs. 4 mos. 0 ds.

Contributory Cerebral Hemorrhage -
Secondary Hemiplegia (R) abt 12 hrs
(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Frank J. Laurence, M. D.
July 8th, 1914 (Address) mt Hope Retreat

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death abt yrs. 4 mos. 0 ds. In the Dont Know State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, Baltimore Md
If not at place of death?

Former or usual residence Baltimore Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gracemount Cemetery 7-10-14

20 UNDERTAKER

ADDRESS

Wm. D. Grooms 118 W. Royal Ave. City

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 6 1914
BUREAU U. S. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH Balto 6454

County Balto (No. _____)

Village or City Odor St.; Ward _____

2 FULL NAME Frederick B Bees

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Unknown

6 DATE OF BIRTH Unknown
(Month) (Day) (Year)

7 AGE about 30 If LESS than 1 day, _____ hrs. _____ yrs. _____ mos. _____ ds. OR _____ mln. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Bees

(Address) 3241 Fair Ave.

15 Filed July 12, 1914 J. E. McClellan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 12, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw him _____ alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Suicide
Poisoned by carbolic acid
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. S. Warner, M. D.

July 12, 1914 (Address) 3241 Fair Ave.

*State the DISEASE CAUSING DEATH, or, in death from ACCIDENTAL CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL 2434 Jefferson St. DATE OF BURIAL July 12, 1914

20 UNDERTAKER Christian Miller ADDRESS 2434 Jefferson St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 7 1914

BUREAU U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 6455
 County Baltimore Thos. Wilson Sanatorium
 Registration Dist. No. 31

Village or City Edw. Behr (No. 7th Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edw. Behr

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Unknown
 (Month) (Day) (Year)

7 AGE 6 yrs. 6 mos. 1 ds. OR 1 day, 1 hrs. 1 min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Infant
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

PARENTS
 10 NAME OF FATHER Edw. Behr
 11 BIRTHPLACE OF FATHER (State or country) Unknown
 12 MAIDEN NAME OF MOTHER Unknown
 13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John K. J.
 (Address) 1111 1st St. N. E.

15 Filed 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 24th, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1914 to 1914

that I last saw h. alive on 1914

and that death occurred on the date stated above, at 1914 m.

The CAUSE OF DEATH* was as follows:

Congenital Heart

Contributory Malnutrition (Duration) 6 yrs. 6 mos. 1 ds.
 Secondary

(Signed) John K. J., M. D.
July 24, 1914 (Address) 1111 1st St. N. E.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death 2 yrs. 2 mos. 2 ds. In the State 1914 yrs. 1914 mos. 1914 ds.

Where was disease contracted, At home
 If not at place of death?
 Former or usual residence Baltimore

19 PLACE OF BURIAL OR REMOVAL Unknown DATE OF BURIAL 1914

20 UNDERTAKER Unknown ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

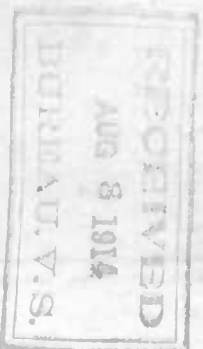
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—grievous*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH 6456 | | STATE OF MARYLAND | |
| County Baltimore | | CERTIFICATE OF DEATH | |
| Village or City Catonsville (No. 64) | | Registration Dist. No. 30 | |
| 2 FULL NAME Mary E. Bennington | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX Fe | 4 COLOR OR RACE white | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word) | |
| 6 DATE OF BIRTH Aug 2nd, 1871 (Month) (Day) (Year) | | | |
| 7 AGE 73 yrs. 10 mos. 10 ds. | | If LESS than 1 day, hrs. OR min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) Maryland | | | |
| PARENTS | 10 NAME OF FATHER Jeremiah Brooks | | |
| | 11 BIRTHPLACE OF FATHER (State or country) Maryland | | |
| | 12 MAIDEN NAME OF MOTHER Mary Thompson | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) Maryland | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs H. E. Doolley (Address) Harford Co. Md | | | |
| 15 Filed July 4, 1914 Maxwell B. Wolf REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH July 3rd, 1914 (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from Nov 25th, 1913 , to July 3rd, 1914 , that I last saw her alive on July 3rd, 1914 , and that death occurred on the date stated above, at 6 P m. The CAUSE OF DEATH* was as follows: | | | |
| Cerebral Hemorrhage (Duration) yrs. 1 mos. 1 ds. | | | |
| Contributory (Secondary) Senile Dementia (Duration) yrs. 6 mos. 6 ds. | | | |
| (Signed) Henry Wade , M. D. July 5, 1914 (Address) Catonsville Md | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. 6 mos. 9 ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence Harford Co. Md. | | | |
| 19 PLACE OF BURIAL OR REMOVAL Delta Penn | | DATE OF BURIAL July 5, 1914 | |
| 20 UNDERTAKER W. M. Raulston | | ADDRESS Green & Sontag | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

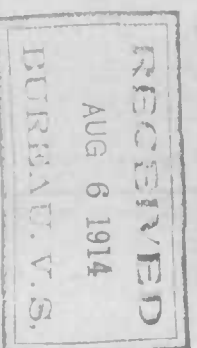
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accedent*; *Revelter wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6457

County BaltimoreVillage or City Rosedale (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 43

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph Berks

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Dec 3, 1913
(Month) (Day) (Year)

7 AGE 7 yrs. 7 mos. 7 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Charles Berks

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Theresa Nischel

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Berks

(Address) Rosedale Md

15 Filed July 4, 1914 St. F. Clayton
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 3, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from July 3, 1914, to July 3, 1914, that I last saw him alive on July 3, 1914

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum
(Duration) yrs. 3 mos. 3 ds.

Contributory (Secondary)

(Signed) W. D. Villars, M. D.
July 4, 1914 (Address) Rosedale Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Honolulu July 2, 1914

20 UNDERTAKER ADDRESS Chas W Lantz Roswell

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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➔ **Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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3458

CD 41

1 PLACE OF DEATH
County Highlandtown

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41

Village or City Highlandtown No. 306 Boldin St. St.; Ward)

2 FULL NAME Anna Gertrude Beyer

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH Dec 4, 1892
(Month) (Day) (Year)

7 AGE 81 yrs. 6 mos. 3 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

PARENTS

10 NAME OF FATHER W. Koch

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Schwan

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amelia Costello
(Address) 306 S Boldin St.

15 Filed July 9 - 1914 W. C. McCluskey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 7, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 4, 1914, to July 7, 1914,
that I last saw her alive on July 6, 1914.

and that death occurred on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma Intestinal
obstruction

(Duration) yrs. mos. ds.
Contributory Embolic
Secondary

(Signed) C. V. Beyer, M. D.
July 8, 1914 (Address) 1008 Pate Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Trinity Cemetery DATE OF BURIAL July 12, 1914
20 UNDERTAKER Louis Heemann ADDRESS 32 S. Broadway

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

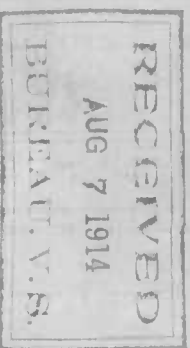
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH 6459 | | STATE OF MARYLAND | |
| County Baltimore | | CERTIFICATE OF DEATH | |
| Village or City (No. W. Wilson, Md. Ward) | | Registration Dist. No. Sanitarium | |
| 2 FULL NAME Mildred Giorskein | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX Female | 4 COLOR OR RACE Hebrew | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) S | |
| 6 DATE OF BIRTH Unknown (Month) (Day) (Year) | | | |
| 7 AGE yrs. 11 mos. ds. OR min. ? If LESS than 1 day, hrs. | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Infant | | | |
| 9 BIRTHPLACE (State or country) Baltimore | | | |
| PARENTS | 10 NAME OF FATHER Joseph Giorskein | | |
| | 11 BIRTHPLACE OF FATHER (State or country) Unknown | | |
| | 12 MAIDEN NAME OF MOTHER " | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) " | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. M. Knapp (Address) W. Wilson, Md. | | | |
| 15 Filed 9 , 191 4 REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH July 29th, 1914 (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from 191 , to 191 , that I last saw him alive on 191 , and that death occurred on the date stated above, at m . The CAUSE OF DEATH* was as follows: B. Pertussis (Duration) yrs. mos. 35 ds. Contributory Broncho pneumonia Secondary (Duration) yrs. mos. 14 ds. (Signed) J. M. Knapp , M. D. July 29, 1914 (Address) W. Wilson, Md. | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. 16 ds. In the State yrs. mos. ds. Where was disease contracted, at home If not at place of death? Baltimore Former or usual residence | | | |
| 19 PLACE OF BURIAL OR REMOVAL Unknown DATE OF BURIAL 191 | | | |
| 20 UNDERTAKER Unknown ADDRESS | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tranition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **6460**County BaltimoreVillage or City Piedmont

(No. _____)

Registration Dist. No. 38

St: _____ Ward)

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Blakiston

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|---------------------------------|--|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>Married</u> |
| 6 DATE OF BIRTH <u>4</u> <u>25</u> <u>1885</u> (Month) (Day) (Year) | | |
| 7 AGE <u>59</u> yrs. <u>4</u> mos. <u>12</u> ds. | | It LESS than 1 day, _____ hrs. OR _____ min. ? |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Business man</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>President of Trust Co of Md</u> | | |

| | |
|--|--|
| 9 BIRTHPLACE (State or country) <u>Londontown St Mary's Co Md</u> | |
| PARENTS | 10 NAME OF FATHER <u>James T. Blakiston</u> |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>St Mary's Co Md</u> |
| | 12 MAIDEN NAME OF MOTHER <u>Ann Thomas</u> |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>St Mary's Co Md</u> |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Blakiston Jr(Address) Piedmont Balto Co Md

15

Filed July 8, 1914M. J. Porter
Deputy Local

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 7, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 6, 1914 to July 7, 1914,
that I last saw him alive on July 7, 1914.and that death occurred on the date stated above, at 8:40 A.M.

The CAUSE OF DEATH* was as follows:

Onset of the lungs consequent on acute heart failure (myocardial) & other consequent on a pneumonia(Duration) _____ yrs. _____ mos. 3 ds.Contributory (Secondary) chronic myocarditis(Duration) _____ yrs. 23 mos. _____ ds.(Signed) J. M. DruryJuly 7, 1914 (Address) Box 100 Baltimore Co Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Barrington Cemetery July 9, 1914

20 UNDERTAKER

H. H. Jenkins & Sons 606 Record St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

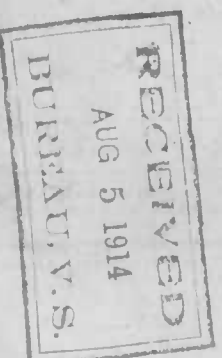
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **Baltimore**
County **Baltimore**

Village or City **Turners Station** (No. **24**) **Balto Co.**

2 FULL NAME **Rosa A. Bland**

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. **44**

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **Colored** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED **married**
(Write the word)

6 DATE OF BIRTH **6 Dec. 1881**
(Month) (Day) (Year)

7 AGE **29** yrs. **7** mos. **ds.** 11 LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work **House wife**
(b) General nature of industry, business, or establishment in which employed (or employer) **House wife**

9 BIRTHPLACE (State or country) **Va**

10 NAME OF FATHER **Henry Parent**

11 BIRTHPLACE OF FATHER (State or country) **Va**

12 MAIDEN NAME OF MOTHER **Alice Peterson**

13 BIRTHPLACE OF MOTHER (State or country) **Va**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant **Arthur Bland**

(Address) **Turners Station**

15 Filed **July 21st 1914** **G. M. McCormick, Jr.**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **July 18**, 191**4**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **July 16**, 191**4**, to **July 18**, 191**4**, that I last saw him alive on **July 18**, 191**4**

and that death occurred on the date stated above, at **9 P.** m.

The CAUSE OF DEATH* was as follows:

Convulsion
Heart exhaustion

(Duration) **X** yrs. **X** mos. **1** ds.

Contributory (Secondary) **Idiopathic Tetanus**

(Duration) **X** yrs. **X** mos. **2** ds.

(Signed) **Jae. L. Brown** M. D.

July 20, 191**4** (Address) **248 So. Third St.**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL **Asbury Cem** DATE OF BURIAL **July 21st 1914**

20 UNDERTAKER **Ann T. Crase** ADDRESS **How 1480 Mosher**

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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C. MCCORMICK, M. D.

SPARROWS PHN

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH Balto. 6462 S.

County Balto.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 444

Village or City Turner Station (No. _____, St. _____ Ward _____)

2 FULL NAME Stille Bond infant Bland

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

6 DATE OF BIRTH July 10th, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) _____

PARENTS

10 NAME OF FATHER Arthur Beaud

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Rosa Latham

13 BIRTHPLACE OF MOTHER (State or country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rosa Beaud
(Address) Turner Sta. Balto Co Md

15 Filed July 11, 1914 G. McKernick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 10, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 1914 to _____, 1914,
that I last saw him _____ alive on _____, 1914,
and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

still born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Mother fell from
Secondary Cherry tree (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G. McKernick, M. D.
July 11, 1914 (Address) Sparks Court

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Sent to Anatomical Dept. DATE OF BURIAL _____, 1914

20 UNDERTAKER John Hopkins Med. School. ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

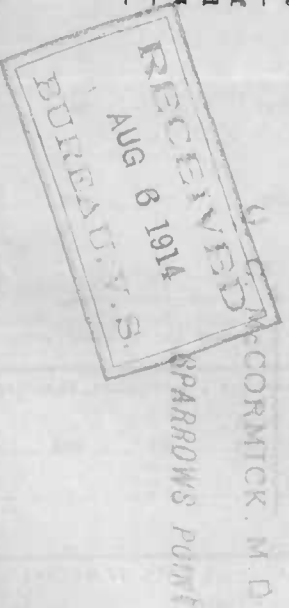
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH 6463
County Baltimore

Village or City Aurora Mills (No. 28) Rosewood State Training School Registration Dist. No. 33
St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME Ora Belle Blossom

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Female ⁴ COLOR OR RACE White ⁵ SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) Single

⁶ DATE OF BIRTH September 4th, 1887
(Month) (Day) (Year)

⁷ AGE 26 yrs. 10 mos. 10 ds. If LESS than 1 day, hrs. OR min. ?

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work Inmate of State Institution for the Feeble Minded
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Maryland

PARENTS
¹⁰ NAME OF FATHER L. Frank Blossom
¹¹ BIRTHPLACE OF FATHER (State or country) Delaware
¹² MAIDEN NAME OF MOTHER Georgiana Collinson
¹³ BIRTHPLACE OF MOTHER (State or country) Maryland

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank W. Keating
(Address) Aurora Mills, Md.

¹⁵ Filed July 14, 1914 Wm. S. S. S. S.
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH July 14th, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from June 3rd, 1914 to July 14th, 1914, that I last saw h. ea alive on July 14th, 1914

and that death occurred on the date stated above, at 7 a. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) — yrs. 1 mos. 11 ds.

Contributory Acute Embolus
Secondary (Duration) — yrs. — mos. 4 ds.

(Signed) Frank W. Keating, M. D.
July 14th, 1914 (Address) Aurora Mills, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 1 yrs. 5 mos. 27 ds. In the State 26 yrs. 10 mos. 10 ds.
Where was disease contracted, If not at place of death?
Former or usual residence Denton, Maryland

¹⁹ PLACE OF BURIAL OR REMOVAL Denton, Caroline Co. Md. DATE OF BURIAL July 16, 1914
²⁰ UNDERTAKER J. F. Eline ADDRESS Rustington

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coat mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misadventure as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Baltimore

Village or City

Highlandtown (No. 621, S. Fourth St.)

Registration Dist. No.

41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Ballack

PERSONAL AND STATISTICAL PARTICULARS

3 SEX _____ 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*
(Write the word)

6 DATE OF BIRTH

June 18th 1914
(Month) (Day) (Year)

7 AGE

_____ yrs. _____ mos. _____ ds. OR _____ min. ?
it LESS than 1 day, _____ hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Nones

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore Co.

PARENTS

10 NAME OF FATHER

Fred Ballack

11 BIRTHPLACE OF FATHER

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

K. Wehr

13 BIRTHPLACE OF MOTHER

(State or country)

Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. K. Ballack

(Address)

621 S. Fourth St.

15

Filed

July 28, 1914 W. E. McLaughlin

REGISTERED

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

7/27/14, 191____
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

7/20/14 191____, to *7/27/14* 191____that I last saw him alive on *7/27/14* 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Iller C. C. C.(Duration) _____ yrs. _____ mos. *14* ds.Contributory
Secondary*M. M. M. M.*(Duration) _____ yrs. _____ mos. *7* ds.

(Signed)

J. J. J. J.

M. D.

7/28/14 191____ (Address) *299 E. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Schwartz's Cem.**July 28, 1914*

20 UNDERTAKER

ADDRESS

*Lilly & Zulu**403 S. Wolfe St.*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 7 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 6465

County Baltimore CoVillage or City Cotonsville Ar (No. Relay)

St.; Ward)

Regist. Lion Dist. No. 402

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Margaret Anne Bradley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Sept 20, 1865
(Month) (Day) (Year)

7 AGE 49 yrs. 10 mos. 17 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Sheldon

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Schoten

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas B Bradley

(Address) Relay Balt Wm

15 Filed July 18, 1914 H. F. H. Hubl
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 10" 1914, to July 17" 1914.

that I last saw her alive on July 11" 1914.

and that death occurred on the date stated above, at 7:45 P m.

The CAUSE OF DEATH* was as follows:

Cancer of abdomen involving the intestines and mesentery
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory same
Secondary
(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) Arthur Williams, M. D.
July 18" 1914 (Address) Elk Ridge Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Grace Cemetery Elk Ridge DATE OF BURIAL July 20" 1914

20 UNDERTAKER Charles R Earls ADDRESS Elk Ridge

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Idantion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **6466**
County **Baltimore**

Village or City **Glenoe** (No. _____) St. _____ Ward _____

2 FULL NAME **Grace Virginia Brewer**

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. **37**

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **White** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) **married**

6 DATE OF BIRTH **unknown**
(Month) **11** (Day) **11** (Year) **11**

7 AGE **about 32** yrs. mos. ds. **OR** LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work **Housewife at beginning of illness**
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) **Maryland**

10 NAME OF FATHER **Jackson Palmer**

11 BIRTHPLACE OF FATHER (State or country) **Maryland**

12 MAIDEN NAME OF MOTHER **Lane Rozier**

13 BIRTHPLACE OF MOTHER (State or country) **Maryland**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Wilton A. Brewer**
(Address) **Glenoe Md.**

15 Filed **July 20, 1914** **B. B. Young MD**
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **July 19, 1914**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **May 25, 1914**, to **July 19, 1914**, that I last saw her alive on **July 19, 1914**

and that death occurred on the date stated above, at **4:30 P. m.**

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

Contributory (Secondary)

(Duration) **8** yrs. mos. ds.
(Signed) **A. R. Mitchell** M. D.
July 19, 1914 (Address) **Monkton, Md.**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS; INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL **H. and B. Co. Cemetery** DATE OF BURIAL **July 20, 1914**

20 UNDERTAKER **Geo. J. Howard** ADDRESS **Henrietta**

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

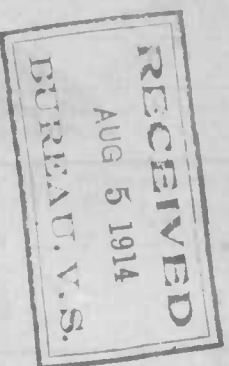
Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 6467
 County Baltimore (No. 120)
 Village or City Leatonville Spring Grove S.H. (No. 120) Ward 30
 2 FULL NAME Elizabeth Bridge

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH unk unk, 1841
 (Month) (Day) (Year)

7 AGE 73 yrs. unk mos. unk ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER unk
 11 BIRTHPLACE OF FATHER (State or country) Maryland
 12 MAIDEN NAME OF MOTHER unk
 13 BIRTHPLACE OF MOTHER (State or country) unk

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Spring Grove S.H. Supt
 (Address) Leatonville Md

15 Filed July 17, 1914 Marshall B. Wosh
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17th, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 21st, 1906, to July 17th, 1914,
 that I last saw h er alive on July 6th, 1914

and that death occurred on the date stated above, at 6 a. m.
 The CAUSE OF DEATH* was as follows:

Chronic Bright Disease
 (Duration) yrs. 12 mos. ds.

Contributory Senile Dementia
 (Secondary) (Duration) yrs. 8 mos. ds.

(Signed) Cheryl Wade, M. D.
July 17, 1914 (Address) Leatonville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death 8 yrs. 3 mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? Balto. Md.
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Anns Cemetery DATE OF BURIAL July 17, 1914
 20 UNDERTAKER H. E. Myler ADDRESS 172 Broadway

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

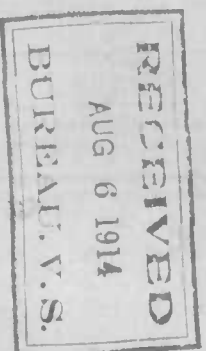
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 da.; *Bronchopneumonia* (secondary), 10 da. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

191

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH* was as follows:

Contributory
Secondary

(Signed)

(Duration) 2 yrs. — mos. — ds.

, 191 (Address) Towson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place Endowment Lane. In the of death — yrs. — mos. 13 ds. State 29 yrs. 8 mos. 1 ds

Where was disease contracted, Family

If not at place of death? Former or usual residence Baltimore

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

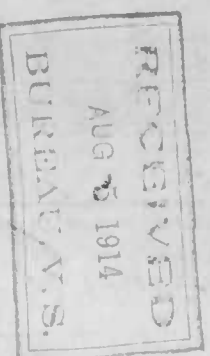
[Approved by the U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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| | | | | | |
|---|--|--|--|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 6469 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Texas Md</u> (No. <u>189</u>) | | St. <u>189</u> Ward <u>37</u> | | Registration Dist. No. <u>37</u> | |
| 2 FULL NAME <u>Burke D. Carter</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED <u>married</u> (Write the word) | | | |
| 6 DATE OF BIRTH <u>Feb 2 1859</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>55</u> yrs. <u>4</u> mos. <u>28</u> ds. If LESS than 1 day, hrs. OR min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Carpenter</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Va.</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Burke D. Carter</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Va</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Virginia Knight</u> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Va</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>B. J. Carter</u> (Address) <u>Warren Md</u> | | | | | |
| 15 Filed <u>9</u> , 191 <u>4</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 18 DATE OF DEATH <u>July 16</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>191</u> to <u>191</u> , that I last saw him alive on <u>191</u> , and that death occurred on the date stated above, at <u>m</u> . The CAUSE OF DEATH* was as follows: <u>Sudden</u> <u>Bobbery from cerebral abnor</u> <u>normal of well depressed</u> <u>fracture of skull</u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. | | | | | |
| Contributory Secondary (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. | | | | | |
| (Signed) <u>B. J. Carter</u> , M. D. <u>July 17</u> , 191 <u>4</u> (Address) <u>Texas Md.</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u> </u> | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Poplar Cemetery</u> DATE OF BURIAL <u>July 19</u> , 191 <u>4</u> | | | | | |
| 20 UNDERTAKER <u>Wm. Brooks</u> ADDRESS <u>Philpott's Mt</u> | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

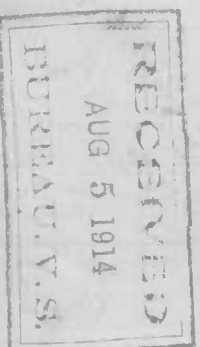
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **6470**
County Baltimore

Village or City Pikesville (No. 154) St; _____ Ward)

Registered No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Arthur Chenoweth

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH 11 18 1833
(Month) (Day) (Year)

7 AGE 80 yrs. 7 mos. 15 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Balto. Co.

10 NAME OF FATHER Mr. Chenoweth

11 BIRTHPLACE OF FATHER (State or country) Balto. Co.

12 MAIDEN NAME OF MOTHER Emily Davis

13 BIRTHPLACE OF MOTHER (State or country) Balto. Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. Chenoweth

(Address) Pikesville, Md.

15 Filed July 11, 1914 Henry A. Naylor
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 3, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April, 1914, to July 3, 1914.

that I last saw him alive on July 2, 1914.

and that death occurred on the date stated above, at 1015 A. M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
& Senile Debility

(Duration) 2 yrs. _____ mos. _____ ds.
Contributory (Secondary) Debility

(Signed) Thomas Taylor, M. D.
July 11, 1914 (Address) Pikesville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Stone Chapel DATE OF BURIAL July 11, 1914

20 UNDERTAKER C. H. Kraft ADDRESS Pikesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

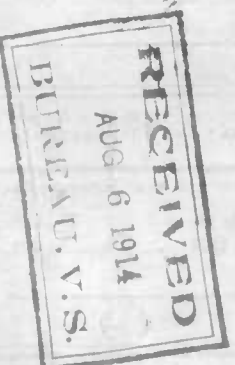
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmorrhage," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. As examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6471

County Baltimore, Md.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 42

Village or City

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mrs. William C. Collings

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)St

6 DATE OF BIRTH

Nov14

(Month)

(Day)

1864
(Year)

7 AGE

53

yrs.

8

mos.

10

ds.

If LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Auctioneer

9 BIRTHPLACE

(State or country)

London

PARENTS

10 NAME OF FATHER

Osceola Collings11 BIRTHPLACE OF FATHER
(State or country)England

12 MAIDEN NAME OF MOTHER

Mary Gelpin13 BIRTHPLACE OF MOTHER
(State or country)England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Anna Spreyer

(Address)

Westminster, Md.

15

Filed

July 24, 1914Westminster

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 24, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 11, 1914, to July 24, 1914that I last saw him alive on July 24, 1914and that death occurred on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows:

Heart & Mitral Insufficiency

(Duration)

yrs.

mos.

ds.

Contributory
SecondaryAc. Dil. Heart

(Duration)

yrs.

mos.

ds.

(Signed)

W. C. Roberts

M. D.

July 24, 1914 (Address) St. Agnes Ha.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,
If not at place of death?

Former or

usual residence

WestminsterMd.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London ParkJuly 27, 1914

20 UNDERTAKER

ADDRESS

Wm. J. T. Roberts North & Penn.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

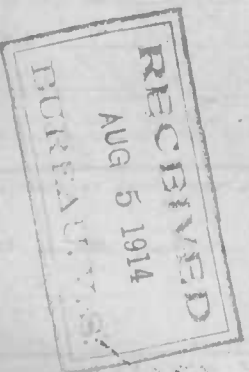
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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| | | | |
|--|--------------------------------|---|--|
| 1 PLACE OF DEATH 6472 | | STATE OF MARYLAND | |
| County <u>Baltimore</u> | | CERTIFICATE OF DEATH | |
| Village or City _____ (No. _____) | | Registration Dist. No. _____ | |
| 2 FULL NAME <u>Dorothy Collins</u> | | [It death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>Mulatto</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | |
| 6 DATE OF BIRTH <u>Unknown</u> | | | |
| (Month) _____ (Day) _____ (Year) _____ | | | |
| 7 AGE <u>9</u> yrs. <u>9</u> mos. <u>0</u> ds. OR <u>1</u> day, <u>0</u> hrs. <u>0</u> min. ? | | 16 DATE OF DEATH <u>July 2nd</u> , 191 <u>4</u> | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> | | (Month) _____ (Day) _____ (Year) _____ | |
| (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | 17 I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____ | |
| 9 BIRTHPLACE (State or country) <u>Baltimore, Md.</u> | | that I last saw h. _____ alive on _____, 191____ | |
| 10 NAME OF FATHER <u>Unknown</u> | | and that death occurred on the date stated above, at _____ m. | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> | | The CAUSE OF DEATH* was as follows: | |
| 12 MAIDEN NAME OF MOTHER <u>Mary Collins</u> | | <u>Gastro Intestinal Intoxication</u> | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> | | (Duration) _____ yrs. <u>1</u> wk. _____ mos. _____ ds. | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | Contributory <u>Malnutrition</u> | |
| (Informant) <u>John Wilson Jr.</u> | | (Duration) _____ yrs. _____ mos. _____ ds. | |
| (Address) <u>Mt Wilson, Md.</u> | | (Signed) <u>John Wilson Jr.</u> , M. D. | |
| 15 | | <u>July 2</u> , 191 <u>4</u> (Address) <u>Baltimore</u> | |
| Filed _____, 191 <u>4</u> | | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | |
| REGISTRAR | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | |
| | | At place of death _____ yrs. _____ mos. <u>8</u> ds. In the State _____ yrs. _____ mos. _____ ds. | |
| | | Where was disease contracted, <u>At home</u> | |
| | | If not at place of death? _____ | |
| | | Former or usual residence <u>Baltimore</u> | |
| | | 19 PLACE OF BURIAL OR REMOVAL <u>Unknown</u> DATE OF BURIAL _____, 191____ | |
| | | 20 UNDERTAKER <u>Unknown</u> ADDRESS _____ | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

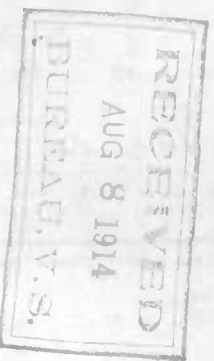
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH **6473**
County Baltimore

Village or City Hamilton (No. _____, St.; _____ Ward)

2 FULL NAME Wm. J. Conrad

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Dec. 17, 1843
(Month) (Day) (Year)

7 AGE 70 yrs. 7 mos. 14 ds. IF LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Joseph Menzel

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Rebecca Strickmann

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elyabeth Conrad

(Address) Hamilton, md

15 W. J. 1914 Clara Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 31, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1913 to July 31, 1914
that I last saw h. 91 alive on July 31, 1914

and that death occurred on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 1 yrs. ____ mos. ____ ds.

Contributory (Secondary) Interstitial Nephritis

(Duration) 1 yrs. ____ mos. ____ ds.

(Signed) Geary G. Long, M. D.

Aug 1, 1914 (Address) Hamilton, md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London, Md

Aug 2, 1914

20 UNDERTAKER

ADDRESS

W. J. Conrad

North an

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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RECEIVED
AUG 5 1914
BUR. ENT. V. S.

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' PLACE OF DEATH 6474

County BaltoVillage or City Hilldale (No. 121)2 FULL NAME Mary E. CarbinSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Sept 22, 1881
(Month) (Day) (Year)

7 AGE 83 yrs. 10 mos. — ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Balto

PARENTS

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (State or country)

Not known

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (State or country)

Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Carbin

(Address)

Hilldale

15

Filed July 24th, 1914A. C. Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 23rd, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1914, to July 23rd, 1914, that I last saw him alive on July 23rd, 1914.

and that death occurred on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Infirmity of Age & Critical Regurgitation(Duration) 2 yrs. 2 mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.(Signed) A. C. Smith, M. D.July 24th, 1914. (Address) W. Paul Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ProvidenceJuly 26th, 1914

20 UNDERTAKER

ADDRESS

Joe B. CochBalto 81

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Tranition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH. 6475 | | STATE OF MARYLAND | |
| County <u>Baltimore</u> | | CERTIFICATE OF DEATH | |
| Village or City <u>(No. 15) Thos. Wilson, Md.</u> | | Registration Dist. No. <u>31</u> | |
| 2 FULL NAME <u>Armeta Cramer</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |

| PERSONAL AND STATISTICAL PARTICULARS | | | |
|--|---|--|--|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>Single</u> | |
| 6 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>4</u> yrs. <u>4</u> mos. <u>4</u> ds. | | If LESS than 1 day, <u>4</u> hrs. OR <u>4</u> min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Infant</u> | | | |
| 9 BIRTHPLACE (State or country) <u>Baltimore</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Unknown</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Thos. Wilson Jr.</u> (Address) <u>Thos. Wilson, Md.</u> | | | |
| 15 Filed <u>9</u> , 191 <u>4</u> REGISTRAR | | | |

| MEDICAL CERTIFICATE OF DEATH | |
|--|----------------------------|
| 16 DATE OF DEATH <u>July 28</u> , 191 <u>4</u> (Month) (Day) (Year) | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>July 28</u> , 191 <u>4</u> , to <u>July 28</u> , 191 <u>4</u> , that I last saw him alive on <u>July 28</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>Thos. Wilson, Md.</u> m. | |
| The CAUSE OF DEATH* was as follows: <u>Malnutrition</u> <u>Hare lip & cleft palate</u> | |
| Contributory (Duration) <u>4</u> yrs. <u>4</u> mos. <u>4</u> ds. <u>Gastric Indigestion</u> Secondary (Duration) <u>4</u> yrs. <u>4</u> mos. <u>4</u> ds. | |
| (Signed) <u>Thos. Wilson Jr.</u> , M. D. <u>July 25</u> , 191 <u>4</u> . (Address) <u>Thos. Wilson, Md.</u> | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>15</u> yrs. <u>15</u> mos. <u>15</u> ds. In the State <u>15</u> yrs. <u>15</u> mos. <u>15</u> ds. Where was disease contracted, <u>At home</u> If not at place of death? Former or usual residence <u>Baltimore</u> | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Unknown</u> | DATE OF BURIAL <u>1914</u> |
| 20 UNDERTAKER <u>Unknown</u> | ADDRESS <u>Unknown</u> |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

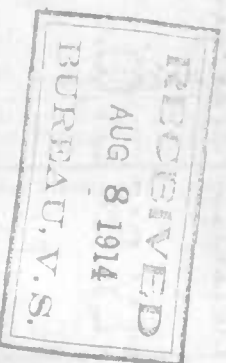
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County BaltimoreVillage or City St. Agnes Hospital (No. 151)St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary C. CrossRegistration Dist. No. 42

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH March 27, 1914
(Month) (Day) (Year)

7 AGE 3 yrs. 3 mos. 28 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Charles L. Cross

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Lindner

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Charles L. Cross(Address) Lock Raven Md

15 Filed July 25, 1914 G. W. Shawell
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 25, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1914 to July 25, 1914, that I last saw her alive on July 25, 1914

and that death occurred on the date stated above, at 5 p. m.
The CAUSE OF DEATH* was as follows:

Swanther(Duration) yrs. mos. ds.Contributory
Secondary(Duration) yrs. mos. ds.

(Signed) Norbert C. Mabel, M. D.
July 25, 1914 (Address) St Agnes Hbr

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 5 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence Lock Raven Md

19 PLACE OF BURIAL OR REMOVAL St. Agnes Hbr DATE OF BURIAL July 27, 1914

20 UNDERTAKER John Burrows ADDRESS Balto

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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1 PLACE OF DEATH 6478

County

Baltimore

Village or City

Ruxton

(No.

Registration Dist. No.

38

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Jan Bell Dobney

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|---|--|
| 3 SEX Female | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed |
| 6 DATE OF BIRTH Sept. 22, 1947 (Month) (Day) (Year) | | |
| 7 AGE 66 yrs. 0 mos. 26 ds. | | If LESS than 1 day, hrs. OR min. ? |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work - None (b) General nature of industry, business, or establishment in which employed (or employer) None | | |
| 9 BIRTHPLACE (State or country) Virginia. W.C. | | |
| PARENTS | 10 NAME OF FATHER Michael Lewis King | |
| | 11 BIRTHPLACE OF FATHER (State or country) Virginia | |
| | 12 MAIDEN NAME OF MOTHER Ray Helen Trull | |
| | 13 BIRTHPLACE OF MOTHER (State or country) Virginia | |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. Wm. H. Dobney

(Address)

Ruxton Balto Co Md

15

Filed

July 18, 1914 M. J. Lorin

REGISTRAR

If more blanks are needed, address State Regls trar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

| | |
|---|--|
| 16 DATE OF DEATH July 18, 1914 (Month) (Day) (Year) | 17 I HEREBY CERTIFY, That I attended deceased from Rux. 1914 to July 17, 1914 that I last saw h. ex. alive on July 17, 1914 and that death occurred on the date stated above, at 6 P. m. The CAUSE OF DEATH* was as follows: Carcinoma of uterus (Duration) 1 yrs. 4 mos. 15 ds. Contributory (Secondary) Carcinoma of Rectum (Duration) yrs. mos. ds. (Signed) Thomas N. Brown, M. D. July 18, 1914 (Address) 1945 Bridge St. |
|---|--|

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

| | |
|------------------------------------|-------------------------------|
| At place of death yrs. mos. ds. | In the State yrs. mos. ds. |
|------------------------------------|-------------------------------|

Where was disease contracted,
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Charlottesville Va

July 18, 1914

20 UNDERTAKER

H. J. Jenkins & Sons Co Orchard Sts.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

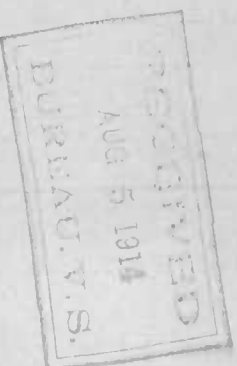
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH 6479 | | STATE OF MARYLAND | |
| County <u>Balto Co</u> | | CERTIFICATE OF DEATH | |
| Village or City <u>Perry Hall</u> (No. <u>42</u>) | | Registration Dist. No. <u>43</u> | |
| 2 FULL NAME <u>Auna Maria Hammer</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word) | |
| 6 DATE OF BIRTH <u>March 4</u> , 19 <u>63</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>57</u> yrs. <u>4</u> mos. <u>11</u> ds. | | It LESS than 1 day, ____ hrs. OR ____ min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) <u>Md</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Edw. Seitz</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Barbara Knauer</u> | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Kathryn Palmer</u> (Address) <u>Perry Hall</u> | | | |
| 15 Filed <u>July 21, 1914</u> <u>W. F. Taylor</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>July 21</u> , 191 <u>4</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>April</u> , 191 <u>3</u> , to <u>July 20</u> , 191 <u>4</u> , that I last saw her alive on <u>July 18</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>1:30</u> a.m. The CAUSE OF DEATH* was as follows: <u>Carcinoma of Uterus</u> (Duration) <u>1 1/2</u> yrs. ____ mos. ____ ds. Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds. (Signed) <u>Walter W. White</u> , M. D. <u>July 21, 1914</u> (Address) <u>1101 Bway</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2), whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? Former or usual residence ____ | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Balto Cem</u> | | DATE OF BURIAL <u>July 24</u> , 191 <u>4</u> | |
| 20 UNDERTAKER <u>Herning & Co</u> | | ADDRESS <u>2008 Orleans</u> | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

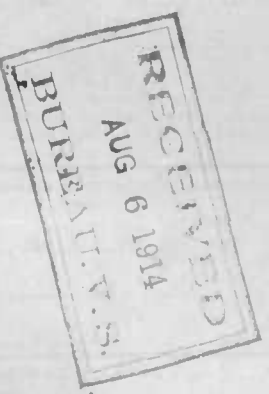
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theuia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Balto. Co.

Village or City West Balto. Station, Lansdowne P. O. (No. 104) St. 1 Ward

2 FULL NAME Gus. Edmund. Davis

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 3^d - - - 1914
(Month) (Day) (Year)

7 AGE 6 yrs. 6 mos. - ds. If LESS than 1 day, - hrs. OR - min. ? -

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto County

10 NAME OF FATHER Harriet Davis

11 BIRTHPLACE OF FATHER (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Purper

13 BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Davis

(Address) West Balto Station

15 Filed July 22, 1914 J. H. Kuhl
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 - 21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 7 - 19, 1914, to 7 - 21, 1914.

that I last saw him alive on 7 - 21, 1914.

and that death occurred on the date stated above, at - m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) - yrs. - mos. - ds.
Contributory (Secondary) Exhaustion

(Duration) - yrs. - mos. - ds.
(Signed) W. Hall, M. D.
7 - 22, 1914 (Address) Mr. Davis

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death - yrs. - mos. - ds. In the State - yrs. - mos. - ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Volstead, Balto. Co. DATE OF BURIAL July 22, 1914

20 UNDERTAKER John. Howards Son ADDRESS 20, Hollister St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

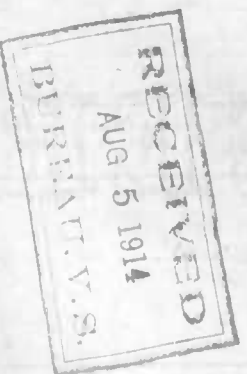
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anthrax," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6481

County

Baltimore

Village or City

Mt Hope Retreat

(No.)

Registration Dist. No.

32

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Jerry S. Davis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married - (Write the word)

6 DATE OF BIRTH

Don't know

(Month) (Day) (Year)

7 AGE

abt 38 yrs. 0 mos. 0 ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Whiskey Rectifier

(b) General nature of industry, business, or establishment in which employed (or employer) Blending spirits etc.

9 BIRTHPLACE (State or country)

Va - Fairfax Co.

PARENTS

10 NAME OF FATHER

Haywood Davis

11 BIRTHPLACE OF FATHER (State or country)

Va

12 MAIDEN NAME OF MOTHER

Mip Stone

13 BIRTHPLACE OF MOTHER (State or country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Record of Mt Hope Retreat

(Address) Mount Hope H.A.

15

Filed July 17, 1914 Wm. G. Queen

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 16, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 10 A.M. to 10 P.M.
July 16, 1914, to July 16, 1914.

that I last saw him alive on July 16, 1914.

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Alcoholic Dementia

abt (Duration) 1 yrs. 0 mos. 0 ds.

Contributory

Ex-Acute Uræmia

abt (Duration) 0 yrs. 0 mos. 10 ds.

(Signed) Frank J. Canning, M. D.

July 17, 1914 (Address) Mt Hope Retreat

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 12 hrs. In the 12 hrs.

Where was disease contracted, Norfolk Va.

If not at place of death?

Former or usual residence Norfolk Va.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Norfolk Va. July 18, 1914

20 UNDERTAKER

ADDRESS

Stewart-Morrison Co 15 W. Eager St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

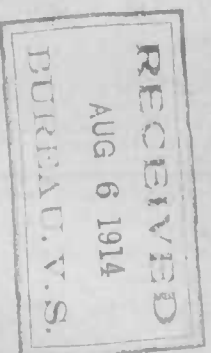
[Approved by U. S. Census and American Public Health Association.]

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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6482
County Baltimore

Village or City Rayville (No. _____)

2 FULL NAME

Robert D. Davis

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 035

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH April 22, 1836
(Month) (Day) (Year)

7 AGE 78 yrs. 2 mos. 10 ds. It LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Blacksmith, Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Charles Davis

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Jane Davis

(Address) Porter, Md

15 July 3, 1914 Joseph B. Baerlin

Filed July 3, 1914 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 2, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1914, to July 3, 1914, that I last saw him alive on July 3, 1914, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Corbic Insufficiency
or Incompetency - Death
Sudden (Duration) Unknown yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Joseph B. Baerlin, M. D.
July 3, 1914 (Address) Porter, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Le. B. Cemetery Rayville July 5, 1914

20 UNDERTAKER ADDRESS

W. R. Taylor 86 St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1. Baerlin

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 da.*; *Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6483

County

Baltimore

Village or City

Arlington

(No.

St.

Ward)

2 FULL NAME

Mrs Nannie Dew

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|--|--|
| 3 SEX Female | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow |
| 6 DATE OF BIRTH Aug 13 th , 1858 (Month) (Day) (Year) | | |
| 7 AGE 55 yrs. 17 mos. 2 ds. | | It LESS than 1 day, hrs. OR min. ? |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) None | | |
| 9 BIRTHPLACE (State or country) Wilson N. C. | | |
| PARENTS | 10 NAME OF FATHER Albert Farmer | |
| | 11 BIRTHPLACE OF FATHER (State or country) N. C. | |
| | 12 MAIDEN NAME OF MOTHER Nancy | |
| | 13 BIRTHPLACE OF MOTHER (State or country) N. C. | |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James W. Swaine

(Address)

Dennore and Swaine

15

Filed

July 16, 1914 William G. Deane

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

| | |
|---|---|
| 16 DATE OF DEATH July 15, 1914 (Month) (Day) (Year) | 17 I HEREBY CERTIFY, That I attended deceased from Jan 1914 to July 15 th 1914, that I last saw her alive on July 15 th 1914, and that death occurred on the date stated above, at 7 P. m. The CAUSE OF DEATH* was as follows: Ascending Spinal Paralysis (Duration) 1 yr. 4 mos. 2 ds. Contributory Malnutrition (Duration) 4 yrs. 4 mos. 2 ds. (Signed) E. B. Ennis, M. D. July 15, 1914 (Address) Arlington Md. *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
|---|---|

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wilson N. C.

July 16, 1914

20 UNDERTAKER

ADDRESS

E. W. Mitchell 1201 W. Fayette St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD · CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremula," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6484

County

Baltimore

Village or City

Pikesville

(No.

7 mile Lane near
Park Heights Ave.

St;

Ward)

Registered No.

32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lewis A. Dill

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

April 10, 1914
(Month) (Day) (Year)

7 AGE

3 yrs. 12 mos. 12 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9 BIRTHPLACE (State or country)

Baltimore Co.

10 NAME OF FATHER

L. Allen Dill

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Margaret Chambers

13 BIRTHPLACE OF MOTHER (State or country)

Dover, Del.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. Thos. Chambers

(Address)

Baltimore, Md.

15

Filed

July 23, 1914 William J. Quinn

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

(91)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 22, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from

July 14, 1914, to July 22, 1914

that I last saw him alive on July 22, 1914

and that death occurred on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows: Staphylococcus

infection involving purulent

membranes of nose and throat

(Duration) yrs. 9 mos. 1 ds.

Contributory (Secondary)

Broncho Pneumonia

(Duration) yrs. 1 ds.

(Signed)

Edmund F. Lindenwald

M. D.

July 22, 1914 (Address) 1616 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Druid Ridge Co. July 23, 1914

20 UNDERTAKER

ADDRESS

Stewart & Mowbray 15 W. Eager St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

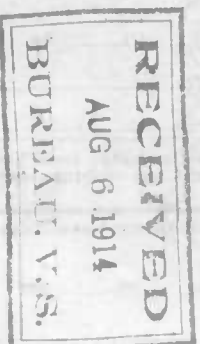
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For FORT-ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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STATE OF MARYLAND

ADDRESS

101

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

6485

County

Village or City

(No.

St;

Ward)

Registered No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Not known

(Month)

(Day)

(Year)

7 AGE

about 71

yrs.

mos.

ds.

It LESS than 1 day, ... hrs. OR ... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Ireland

PARENTS

10 NAME OF FATHER

Paddy Dolan

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Alice Heilly

13 BIRTHPLACE OF MOTHER (State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Margaret Dolan

(Address)

Halethorpe, Md.

15

Filed

July 6, 1914

Marshall B. West,

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 4, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 1, 1913, to July 4, 1914,

that I last saw him alive on July 4, 1914,

and that death occurred on the date stated above, at 4 P. M.,

The CAUSE OF DEATH* was as follows:

Acute hemorrhage
exhaustion

(Duration) yrs. mos. ds.

Contributory (Secondary)

Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. T. McGuire, M. D.

July 5, 1914. (Address) 1042 Edgewood Ave. N.E.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bosnia, Ohio July 7, 1914

20 UNDERTAKER

ADDRESS

J. T. McGuire, 1042 Edgewood Ave. N.E.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

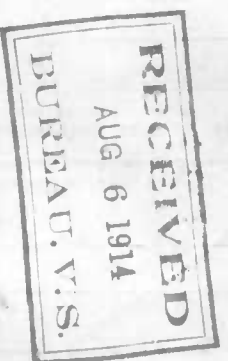
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH 6486 | | STATE OF MARYLAND | |
| County Baltimore | | CERTIFICATE OF DEATH | |
| Village or City (No. 104) Thos Wilson, Md. | | Registration Dist. No. 31 | |
| 2 FULL NAME Catherine Donaldson | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX Female | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) S | |
| 6 DATE OF BIRTH Unknown (Month) (Day) (Year) | | | |
| 7 AGE 9 yrs. 9 mos. 9 ds. OR 1 day, 1 hrs. 1 min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work Infant (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) Baltimore | | | |
| PARENTS | 10 NAME OF FATHER Wm. Donaldson | | |
| | 11 BIRTHPLACE OF FATHER (State or country) Unknown | | |
| | 12 MAIDEN NAME OF MOTHER Unknown | | |
| 13 BIRTHPLACE OF MOTHER (State or country) Unknown | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Franklin Jr. (Address) Wm Wilson, Md. | | | |
| 15 | | | |
| 16 MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH July 20th, 1914 (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from 1914 to 1914 that I last saw him alive on 1914 and that death occurred on the date stated above, at 1914 m. The CAUSE OF DEATH* was as follows: Ilis Colitis (Duration) 1 yrs. 1 mos. 1 ds. Contributory Toxic Secondary (Duration) 1 yrs. 1 mos. 1 ds. (Signed) Franklin Jr. , M. D. July 20, 1914 (Address) Wm Wilson, Md. | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death 1914 yrs. 1914 mos. 1914 ds. In the State 1914 yrs. 1914 mos. 1914 ds. Where was disease contracted, At home If not at place of death? Former or usual residence Baltimore | | | |
| 19 PLACE OF BURIAL OR REMOVAL Unknown | | DATE OF BURIAL 1914 | |
| 20 UNDERTAKER Unknown | | ADDRESS | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

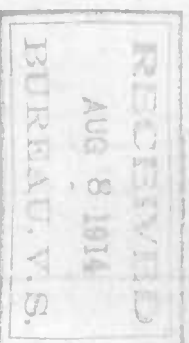
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations of statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6487

County

Balto

Village or City

Lauraville

(No.

Alisia & Bayford St.

Registration Dist. No.

31

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Howard T. Kloster Jr

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|---|---|
| 3 SEX Male | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Infant |
| 6 DATE OF BIRTH June 18, 1914 (Month) (Day) (Year) | | |
| 7 AGE 0 yrs. 0 mos. 21 ds. If LESS than 1 day, hrs. ? OR min. ? | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Infant | | |
| 9 BIRTHPLACE (State or country) Lauraville | | |
| PARENTS | 10 NAME OF FATHER Howard T. Kloster | |
| | 11 BIRTHPLACE OF FATHER (State or country) Burlington N. J. | |
| | 12 MAIDEN NAME OF MOTHER E. Barber | |
| | 13 BIRTHPLACE OF MOTHER (State or country) Lauraville Md | |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Howard T. Kloster Jr
Lauraville Md

(Address)

15

Filed

7/10, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 9, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 7, 1914 to July 9, 1914
that I last saw him alive on July 9, 1914

and that death occurred on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis
(Duration) yrs. mos. ds.
Contributory (Secondary) Congestion of Lungs
(Duration) yrs. mos. ds.
(Signed) J. Lewis Smith, M. D.
July 9, 1914 (Address) Lauraville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

7/10, 1914

20 UNDERTAKER

ADDRESS

Wm. Cook

502 E. North Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

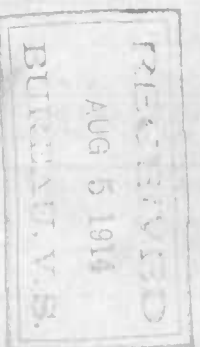
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative *causality* of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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6488

1 PLACE OF DEATH

County Baltimore Thos. Wilson, Sanitarium (No. MA Wilson, Md.)

Village or City Thos. Doughty (No. MA Wilson, Md.)

2 FULL NAME Thos. Doughty

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

STATE OF MARYLAND
CERTIFICATE OF DEATH
Registration Dist. No. 31

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) X

6 DATE OF BIRTH Unknown
(Month) (Day) (Year)

7 AGE 1 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ? If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mrs. Edmonia Doughty

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Doughty Jr
(Address) 1st Wilson Rd

15 Filled 9, 1914
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 23rd, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 23rd, 1914 to July 23rd, 1914
that I last saw him alive on July 23rd, 1914
and that death occurred on the date stated above, at 1st Wilson Rd, M. D.
The CAUSE OF DEATH* was as follows:
Pertussis
(Duration) yrs. mos. 21 ds.
Contributory Bronchopneumonia
Secondary (Duration) yrs. mos. ds.
(Signed) John Doughty Jr, M. D.
July 23, 1914 (Address) 1st Wilson Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.
Where was disease contracted, at home
if not at place of death? Baltimore
Former or usual residence Baltimore

19 PLACE OF BURIAL OR REMOVAL Unknown DATE OF BURIAL 1914

20 UNDERTAKER Unknown ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

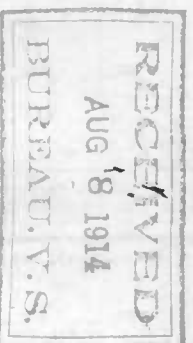
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Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6489

County BaltimoreVillage or City mt winans (No. _____)Registration Dist. No. 43

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME none

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX X 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) X

6 DATE OF BIRTH 7 19, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. OR _____ min. ?
If LESS than 1 day, _____ hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Baltimore county

10 NAME OF FATHER Ernest Eagle

11 BIRTHPLACE OF FATHER (State or country) Baltimore city

12 MAIDEN NAME OF MOTHER Amelia Frank

13 BIRTHPLACE OF MOTHER (State or country) Baltimore city

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. J. B. Hall(Address) Mt. Winans, Md

15 Filed July 24, 1914 J. H. Ruhl

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

16 DATE OF DEATH Miss Carnegie, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 7-19-, 1914, to 7-19-, 1914.

that I last saw him alive on July 7-19, 1914.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Miss Carnegie by passing
& falling back furniture

Still-Birth (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. B. Hall, M. D.

7-20, 1914. (Address) Mt Winans

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Low Back Lot DATE OF BURIAL July 19, 1914

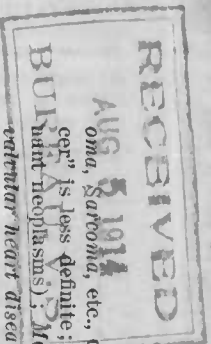
20 UNDERTAKER Ernest Eagle ADDRESS Mt. Winans

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

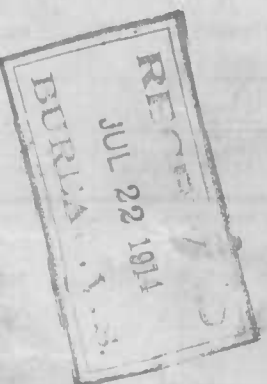
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*



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1 PLACE OF DEATH

6490

County

Baltimore

Village or City

Barney

(No.

Registration Dist. No.

143

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Eichler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

Jan. 9th, 1839

(Month)

(Day)

(Year)

7 AGE

75 yrs. 6 mos. 5 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Eichler

(Address)

Fullerton

15

Filed July 15, 1914 F. H. Clayton

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 14, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY That I attended deceased from

June 29, 1914, to July 14, 1914,

that I last saw him alive on July 11, 1914,

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Infirmities of Old Age

(Duration) — yrs. 6 mos. — ds.

Contributory (Secondary)

Arterio Sclerosis

(Duration) — yrs. 6 mos. — ds.

(Signed)

Morris B. Green M. D.

July 15, 1914 (Address) Hamilton Balto.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL

July 16, 1914

20 UNDERTAKER

Grace M. Tengel

Fullerton

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

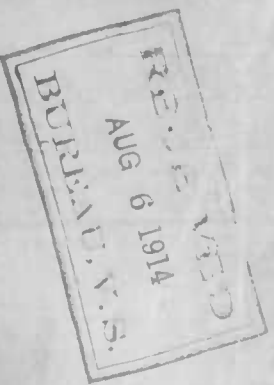
Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—(coal mining, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*; *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—Accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be sketched under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH **6491**
County Balto.

Village or City Mt Winans (No. _____) St.; _____ Ward)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant Emwacht

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH July 25, 1914
(Month) (Day) (Year)

7 AGE Still Birth If LESS than 1 day, ____ hrs. ____ yrs. ____ mos. ____ ds. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Balto Md

10 NAME OF FATHER Fred H. Emwacht

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Cora O. Ruhl

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred. Emwacht

(Address) Mt Winans Md.

15 Filed July 25, 1914 F. H. Ruhl

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 25, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw him _____ alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still Born

Contributory (Duration) ____ yrs. ____ mos. ____ ds.
Secondary Congenital Defects

(Signed) Frank H. Ruhl, M. D.
July 25, 1914 (Address) Lawrence

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Linden Park DATE OF BURIAL July 26, 1914

20 UNDERTAKER J. B. Cook ADDRESS Balto Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

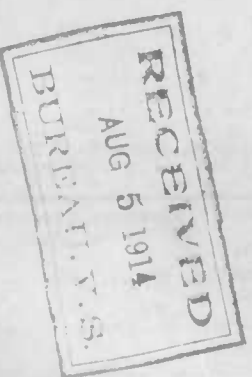
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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6492
1 PLACE OF DEATH
County Baltimore

Village or City Lockeysville (No. _____, _____ St.; _____ Ward)

2 FULL NAME Mary Elizabeth Euser

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 37

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Undivided
(Write the word)

6 DATE OF BIRTH Feb. 18, 1884
(Month) (Day) (Year)

7 AGE 72 yrs. 4 mos. 18 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balt. Md

10 NAME OF FATHER George Tracey

11 BIRTHPLACE OF FATHER (State or country) Balt. Co. Md

12 MAIDEN NAME OF MOTHER Rose Anna Griffith

13 BIRTHPLACE OF MOTHER (State or country) Hampstead Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Irving Euser
(Address) Lockeysville Md

15 Filed July 6, 1914 J. H. Drach Md
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 6, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1914, to July 5th, 1914, that I last saw him alive on July 5th, 1914

and that death occurred on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

The infirmities of age
General debility

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Hepatic Colic
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Drach, M. D.
July 6, 1914 (Address) Lockeysville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Black Rock Cemetery DATE OF BURIAL July 8th, 1914

20 UNDERTAKER Wm. C. Brooks ADDRESS Sparks Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—decident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6493County BaltimoreVillage or City St. Agnes Hospital (No. 152)Registration Dist. No. 42St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Baby Frankhamel (Henry T.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June 27, 1914
(Month) (Day) (Year)

7 AGE 5 yrs. 5 mos. 5 ds. OR LESS than 1 day, 5 hrs. 5 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Co. Md.

PARENTS
10 NAME OF FATHER Henry O Frankhamel
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Josephine Korman
13 BIRTHPLACE OF MOTHER (State or country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry O Frankhamel(Address) Walters - Md

15 Filed July 6, 1914 Geo A Shurt
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 2, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from June 27, 1914 to July 2, 1914

that I last saw him alive on July 2, 1914

and that death occurred on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Obstruction
(Duration) 7 yrs. 5 mos. 5 ds.

Contributory
Secondary

(Signed) Geo A Shurt, M. D.
July 2, 1914 (Address) St Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 5 yrs. 5 mos. 5 ds. In the State 5 yrs. 5 mos. 5 ds.

Where was disease contracted, If not at place of death?

Former or usual residence St Agnes Hospital

19 PLACE OF BURIAL OR REMOVAL Landon Park DATE OF BURIAL July 5, 1914

20 UNDERTAKER Jas. B Smith ADDRESS 1000 N. Dupont

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6494
 County Baltimore 104
 Village or City Ches. Wilson Sanatorium
 (No. M. Wilson, Md. St. Ward)
 2 FULL NAME Gertrude Faver
 [It death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
 6 DATE OF BIRTH Unknown
 (Month) (Day) (Year)
 7 AGE 23 yrs. 0 mos. 0 ds. It LESS than 1 day, 0 hrs. OR 0 min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Infant
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore
 10 NAME OF FATHER John Faver
 11 BIRTHPLACE OF FATHER (State or country) Unknown
 12 MAIDEN NAME OF MOTHER Unknown
 13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) John Faver
 (Address) 1214 Wilson, Md.

15 Filed 9, 1914 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 31

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 24th, 1914
 (Month) (Day) (Year)
 17 I HEREBY CERTIFY, That I attended deceased from

1914 to 1914
 that I last saw h. alive on 1914

and that death occurred on the date stated above, at Ches. Wilson Sanatorium m.

The CAUSE OF DEATH* was as follows:

Ilio Colitis

(Duration) 35 yrs. 0 mos. 0 ds.

Contributory
 Secondary

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) John Faver, M. D.
July 24, 1914. (Address) M. Wilson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 2 mos. 2 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, at home
 It not at place of death?

Former or usual residence Baltimore

19 PLACE OF BURIAL OR REMOVAL Unknown DATE OF BURIAL 1914

20 UNDERTAKER Unknown ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County BaltoVillage or City Ganton (No. 913 S East Ave st.; Ward)

2 FULL NAME

Mary E. Trechely

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH April 20, 1913
(Month) (Day) (Year)

7 AGE 1 yrs. 3 mos. 8 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto-Co. Md.

PARENTS
10 NAME OF FATHER John T. Trechely
11 BIRTHPLACE OF FATHER (State or country) Balto-Co.
12 MAIDEN NAME OF MOTHER Catharine Trechely
13 BIRTHPLACE OF MOTHER (State or country) Balto-Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John T. Trechely(Address) 913 S. East Ave.

15 Filed July 29, 1914 W. E. McManis
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 28, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1914, to July 28, 1914,
that I last saw her alive on July 28, 1914

and that death occurred on the date stated above, at 12²⁵ m.
The CAUSE OF DEATH* was as follows:

Enterocolitis
(Duration) yrs. mos. 14 ds.

Contributory Eclampsia
Secondary (Duration) yrs. mos. 1 ds.

(Signed) M. J. McManis, M. D.
July 29, 1914 (Address) 839 S. Ellwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Catholic Church July 30, 1914

20 UNDERTAKER ADDRESS

Lilly Zeiler 403 S. Molt

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

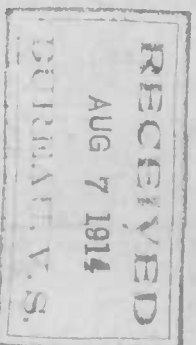
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm-laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or NONFATAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

6495

County

Baltimore

Village or City

Canton

(No.

1533 S. Clinton

St.;

Ward)

Registration Dist. No.

41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Catherine E. Finerty

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the words)

Single

6 DATE OF BIRTH

March 4, 1994

(Month)

(Day)

(Year)

7 AGE

— yrs. 4 mos. 17 ds.

It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

Michael Finerty

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Margaret Cunningham

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Michael Finerty

(Address)

1533 S. Clinton St.

15

Filed

July 22, 1914

W. E. McClaugherty

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 21, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 22, 1914 to July 21, 1914

that I last saw her alive on July 21, 1914

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 7 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

D. D. Jones

M. D.

July 22, 1914 (Address) 3116 O'Sumner Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacred Heart Cemetery

July 23, 1914

20 UNDERTAKER

ADDRESS

J. H. C. Fuller

221 N. Broadway

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without ~~more~~ precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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RECEIVED

AUG 7 1914

BUREAU. V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Balto.

6498

104

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 44

Village or City St Helena (No.) St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ada Loretta Fisher

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH April 18th, 1914
(Month) (Day) (Year)

7 AGE 3 12 yrs. 12 mos. 12 ds. OR 1 day, 12 hrs. 12 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) St Helena Balto Co.

PARENTS
10 NAME OF FATHER Harry E. Fisher
11 BIRTHPLACE OF FATHER (State or country) Balto. Co. Md
12 MAIDEN NAME OF MOTHER Hattie L. Perkins
13 BIRTHPLACE OF MOTHER (State or country) Balto. Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hattie L. Fisher
(Address) St Helena, Balto. Co. Md

15 Filed July 31st, 1914 G. J. McCormick M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 31st, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1914, to July 31, 1914.

that I last saw her alive on July 30th, 1914.

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intertic

(Duration) 10 yrs. 10 mos. 10 ds.

Contributory Inoperable Heart
Secondary

(Duration) 3 yrs. 12 mos. 12 ds.

(Signed) G. J. McCormick, M. D.
July 31, 1914. (Address) Spacious Point

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 12 yrs. 12 mos. 12 ds. In the State 12 yrs. 12 mos. 12 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mr. Carmel Rem. DATE OF BURIAL August 20, 1914

20 UNDERTAKER John Herwig ADDRESS Balto City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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6499

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 38[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]1 PLACE OF DEATH
County BaltimoreVillage or City Ruxton (No. _____, St.; _____ Ward)2 FULL NAME Infant of Alfred & Ellen Fisher

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M- 4 COLOR OR RACE W- 5 SINGLE, Infant
MARRIED, WIDOWED, OR DIVORCED
(Write the word)6 DATE OF BIRTH July 2, 1914
(Month) (Day) (Year)7 AGE Still born It LESS than
1 day.....hrs.
yrs.....mos.....ds. OR.....min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work _____(b) General nature of industry,
business, or establishment in
which employed (or employer) _____9 BIRTHPLACE
(State or country)10 NAME OF FATHER Alfred Fisher11 BIRTHPLACE OF FATHER
(State or country) Md -12 MAIDEN NAME OF MOTHER Ellen Boone13 BIRTHPLACE OF MOTHER
(State or country) Md -

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. M. M. M.(Address) Baltimore Md -15 Filed July 3, 1914 M. G. Porter
Deputy Local

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 2, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
_____, 191____, to _____, 191____,

that I last saw him _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m,

The CAUSE OF DEATH* was as follows:

Still born -
Cord around neck & premature rupture
of membranes (Duration) _____ yrs. _____ mos. _____ ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. M. M., M. D.July 2, 1914 (Address) 327 N. E. Baltimore Md.*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDEN-
TAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
if not at place of death? _____Former or
usual residence _____

19 PLACE OF BURIAL OR REMOVAL

New Cathedral Cem DATE OF BURIAL 7-3, 1914

20 UNDERTAKER

Wm. W. Fisher ADDRESS 1111 N. E. Baltimore Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

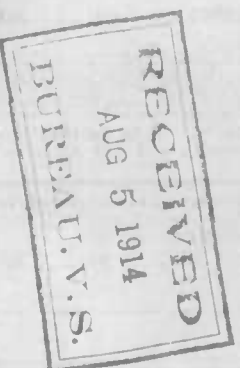
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Iunition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificate.

1 PLACE OF DEATH 6500
County Baltimore Co

Village or City Catonsville (No. 84, Winters Ave)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 96

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ida Morby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Oct 26, 1_____, (Month) (Day) (Year)

7 AGE 8 yrs. 8 mos. ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) X

9 BIRTHPLACE (State or country) Balto Md.

10 NAME OF FATHER Eduard B Forby

11 BIRTHPLACE OF FATHER (State or country) Chatto Tenn

12 MAIDEN NAME OF MOTHER Ida Matthews

13 BIRTHPLACE OF MOTHER (State or country) New Jersey

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida B Forby

(Address) 84 Winters Ave

15 Filed July 24, 1914 Marshall B. Lord REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 23rd, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 18th, 1914, to July 23rd, 1914.

that I last saw him alive on July 22nd, 1914.

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ____ yrs. 2 mos. ____ ds.

Contributory Cerebral Meningitis & Secondary Convulsions

(Duration) ____ yrs. ____ mos. 6 ds.

(Signed) W. C. Hadmao, M. D.

July 24th, 1914. (Address) Catonsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Western Star Cem July 24, 1914

20 UNDERTAKER ADDRESS

Edward W. Pye 6 Winters Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 6 1914
BUREAU, U. S.

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| | | | | | |
|---|--|--|---|--|--|
| 1 PLACE OF DEATH 6501 | | | DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS | | |
| County Baltimore | | | STANDARD CERTIFICATE OF DEATH | | |
| Township or Village or City Ft Howard | | | State of Maryland | | |
| (No. _____) | | | Registered No. 444 | | |
| 2 FULL NAME (Infant Stillborn) Fordney | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | | |
| 3 SEX Male | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single | 16 DATE OF DEATH July 23, 1914 (Month) (Day) (Year) | | |
| 6 DATE OF BIRTH July 23, 1914 (Month) (Day) (Year) | | | 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m. | | |
| 7 AGE Stillborn yrs. _____ mos. _____ ds. or If LESS than 1 day, _____ hrs. _____ min. ? | | | The CAUSE OF DEATH* was as follows: Stillborn | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) | | | (Duration) _____ yrs. _____ mos. _____ ds. | | |
| 9 BIRTHPLACE (State or country) Ft Howard Md | | | Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. | | |
| PARENTS | 10 NAME OF FATHER Walter E. Fordney | (Signed) J. G. Schilder , M. D. July 23, 1914 (Address) Ft Howard Md | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) Laurens Pa | * State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| | 12 MAIDEN NAME OF MOTHER Allie M. Barr | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. in the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death ? _____ Former or usual residence _____ | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) Quaryville Pa | 19 PLACE OF BURIAL OR REMOVAL Oak Lawn | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Walter E. Fordney (Address) Ft Howard Md | | | DATE OF BURIAL July 24, 1914 | | |
| 15 Filed July 23, 1914 | G. H. McCormick Md REGISTRAR | | 20 UNDERTAKER John A. Moran | | |
| ADDRESS Baltimore | | | ADDRESS Baltimore | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

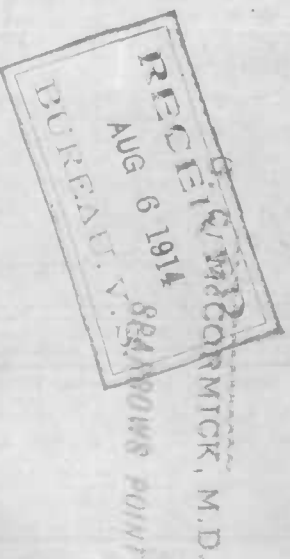
[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaster, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anacmia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hæmorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyæmia, septicæmia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.



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| | | | | | |
|---|--|--|--|---|--|
| 1 PLACE OF DEATH County <u>Balto</u> | | 6502 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Pleasant Hill</u> | | No. <u>md</u> | | Registration Dist. No. <u>33</u> | |
| 2 FULL NAME <u>Harry S Fox</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>widower</u> | | | |
| 6 DATE OF BIRTH <u>Nov 3</u> , 18 <u>68</u> (Month) (Day) (Year) | | 7 AGE <u>45</u> yrs. <u>8</u> mos. <u>6</u> ds. It LESS than 1 day, hrs. OR min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Balto Co Md</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>George Fox</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>New Jersey</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Susan Brown</u> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Balto Co Md</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Georgiana Cook</u> (Address) <u>Crings Mills Md</u> | | | | | |
| 15 Filed <u>July 10</u> , 191 <u>4</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>July 9th</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>March 8</u> , 191 <u>4</u> , to <u>July 9th</u> , 191 <u>4</u> , that I last saw him alive on <u>July 9th</u> , 191 <u>4</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Laryngeal & Pulmonary Tuberculosis</u> (Duration) <u>10</u> yrs. <u>0</u> mos. <u>0</u> ds. | | | | | |
| Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. | | | | | |
| (Signed) <u>Wm. H. H. H.</u> , M. D. <u>July 10</u> , 191 <u>4</u> (Address) <u>Reston Md</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____ | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Pleasant Hill</u> | | | | DATE OF BURIAL <u>July 11</u> , 191 <u>4</u> | |
| 20 UNDERTAKER <u>J. F. Eline</u> | | | | ADDRESS <u>Reston Md</u> | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

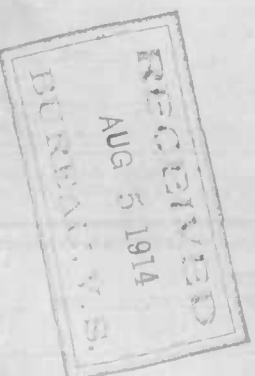
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonæum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-renal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | |
|---|--|--|--|--|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 6496 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Baltimore</u> | | No. <u>3412 Fairmount St.</u> | | Registration Dist. No. <u>41</u> | |
| 2 FULL NAME <u>Baby + rank</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] <u>Still-Birth</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>M</u> | 4 COLOR OR RACE <u>W</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | | | |
| 6 DATE OF BIRTH <u>7/2/14</u> (Month) (Day) (Year) | | 16 DATE OF DEATH <u>7/2/14</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>4 mo</u> Yrs. mos. ds. OR min. ? | | 17 I HEREBY CERTIFY, That I attended deceased from <u>7/2/14</u> , 191 <u>4</u> , to <u>7/2/14</u> , 191 <u>4</u> , that I last saw him alive on <u>7/1/14</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>4 a</u> m. The CAUSE OF DEATH* was as follows: <u>Premature Birth</u> | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) | | 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence | | | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | Contributory <u>Suburban</u> Secondary | | | |
| PARENTS | 10 NAME OF FATHER <u>Henry + Frank</u> | (Signed) <u>H. H. Permann</u> , M. D. <u>7/2/14</u> , 191 <u>4</u> (Address) <u>2919 E. Balto. St.</u> | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u> | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| | 12 MAIDEN NAME OF MOTHER <u>+ Lorence Grasson</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Baltimore</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE <u>Henry Frank</u> (Informant) (Address) <u>3412 Fairmount St.</u> | | | | | |
| 15 Filed <u>July 3</u> , 191 <u>4</u> <u>W. E. McLaughlin</u> Registrar | | 19 PLACE OF BURIAL OR REMOVAL <u>St. Margaret</u> | | DATE OF BURIAL <u>July 4</u> , 191 <u>4</u> | |
| | | 20 UNDERTAKER <u>Philip Herwig</u> | | ADDRESS <u>2016 Ocean</u> | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

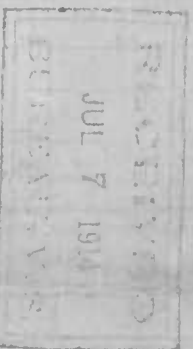
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scout, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—Homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6503

County

Baltimore

Village or City

Back

(No.)

Middle River, Md.

Ward

Registration Dist. No.

44

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Matthew Frank

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

August 19, 1887

(Month)

(Day)

(Year)

7 AGE

27

yrs.

3

mos.

9

ds.

If LESS THAN 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore

PARENTS

10 NAME OF FATHER

Joseph Frank

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Barbier

13 BIRTHPLACE OF MOTHER

(State or country)

York Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Signature)

Chas. R. Read

(Address)

2202 Fairview St.

15

Filed

July 24, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 28, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, that I attended deceased from

July 27, 1914 to July 28, 1914

that I last saw him alive on July 27, 1914

and that death occurred on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency
also suffering from
severe diarrhoea and
weakness (Duration) yrs. mos. ds.

Contributory
Secondary

Explanation

(Duration)

yrs.

mos.

ds.

(Signed) Frank O. Barrett, M. D.

July 28, 1914 (Address) 15 N. Carey St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeem July 30, 1914

20 UNDERTAKER

ADDRESS

Henry Hook Back

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| 1 PLACE OF DEATH | | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|---|--|---|---|-------------------------------------|
| County <u>Baltimore</u> | | | Registration Dist. No. <u>30</u> | |
| Village or City <u>Caleasville, Spring Grove S.H.</u> (No. <u>79</u>) | | | St. <u> </u> Ward <u> </u> | |
| 2 FULL NAME <u>John Franklein</u> | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word) | | |
| 6 DATE OF BIRTH <u>Sept 5th, 1885</u> (Month) (Day) (Year) | | | | |
| 7 AGE <u>28</u> yrs. <u>10</u> mos. <u>21</u> ds. If LESS than 1 day, hrs. OR min. ? | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer.</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u> | | | | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | | | |
| PARENTS | 10 NAME OF FATHER <u>Edward Franklein</u> | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Ida Snyder</u> | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Edward Franklein</u> (Address) <u>Severn, Md</u> | | | | |
| 15 Filed <u>July 26, 1914</u> <u>Marshall B West</u> REGISTRAR | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | |
| 16 DATE OF DEATH <u>July 26th, 1914</u> (Month) (Day) (Year) | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>June 19th, 1914</u> to <u>July 26th, 1914</u> , that I last saw him alive on <u>July 25th, 1914</u> , and that death occurred on the date stated above, at <u>10 a. m.</u> , The CAUSE OF DEATH* was as follows: | | | | |
| <u>Valvular Disease of Heart</u> (Duration) yrs. mos. ds. | | | | |
| Contributory (Secondary) <u>Mercurial Disease</u> (Duration) yrs. mos. ds. | | | | |
| (Signed) <u>J. Berg</u> , M. D. <u>July 26, 1914</u> (Address) <u>Caleasville, Md</u> | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. | | | | |
| Where was disease contracted, If not at place of death? Former or usual residence <u>Anne Arundel Co. Md</u> | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Caleasville, Md</u> | | | | DATE OF BURIAL <u>July 28, 1914</u> |
| 20 UNDERTAKER <u>John J. Fahey & Son</u> | | | | ADDRESS <u>1318 Light St</u> |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

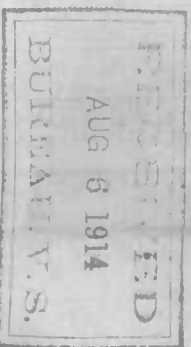
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As thena," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6505

County BaltoVillage or City near Glyndon No. 61 mdSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 33

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ethel E Frantz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

April 5, 1904
(Month) (Day) (Year)

7 AGE

8 yrs. 3 mos. 16 ds.If LESS than
1 day, ... hrs.
OR ... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Balto co md

PARENTS

10 NAME OF FATHER

Ernest Frantz

11 BIRTHPLACE OF FATHER (State or country)

Balto co md

12 MAIDEN NAME OF MOTHER

Flurence Kendig

13 BIRTHPLACE OF MOTHER (State or country)

Balto co md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Flurence Frantz

(Address)

Glyndon md

15

Filed July 22, 1914 Wm. S. S. S.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 21, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 19, 1914, to July 21, 1914.that I last saw her alive on July 21, 1914.and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Measles(Duration) yrs. mos. 3 ds.

Contributory

Tracheitis & pneumonia

Secondary

measles

(Duration) yrs. mos. ds.

(Signed)

J. R. R. R.

M. D.

July 23, 1914 (Address) Glyndon md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

David Ridge County July 23, 1914

20 UNDERTAKER

ADDRESS

J. F. Eline Real Estate

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Baltimore

6506

(40)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

43

Village or City

Raspburg

(No.)

Hamilton Ave

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William Frazier

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

2 10 1837
(Month) (Day) (Year)

7 AGE

76 yrs 5 mos 6 ds.
If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Moulder (retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. C. has Daughaday

(Address)

Raspburg Md

15

Filed

July 17, 1914

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

7 16 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 21, 1914, to July 16, 1914,
that I last saw him alive on *July 16, 1914*and that death occurred on the date stated above, at *12 40 P. m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver
(secondary) (Duration) *1 1/2* yrs. *1 1/2* mos. ds.

Contributory

Carcinoma of stomach(Duration) *1 1/2* yrs. *1 1/2* mos. ds.

(Signed)

A. L. McKinnon

M. D.

July 16, 1914 (Address) *Raspburg*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

West Oxford Cemetery July 18, 1914

20 UNDERTAKER

ADDRESS

Friedrich Lassar & Sons Fullerton Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

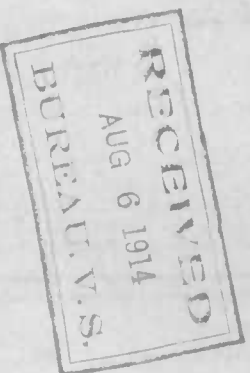
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

6507

County

Balto

Village or City

Raspburg

(No.)

Maine

Registration Dist. No.

43

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ernst Fricks

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

March 15, 1885

(Month)

(Day)

(Year)

7 AGE

29 yrs.

4 mos.

2 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Balto

PARENTS

10 NAME OF FATHER

John H. Fricks

11 BIRTHPLACE OF FATHER

(State or country)

Balto

12 MAIDEN NAME OF MOTHER

Katherine M.

13 BIRTHPLACE OF MOTHER

(State or country)

Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John H. Fricks

(Address)

Raspburg

15

Filed

191

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 17, 1914

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

May 1, 1914, to July 17, 1914.

that I last saw him alive on July 14, 1914.

and that death occurred on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed)

J. H. Clayson, M. D.

July 18, 1914. (Address) Oberlin Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Balto Cemetery

July 19, 1914

20 UNDERTAKER

ADDRESS

John Herold

2008 Orleans

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

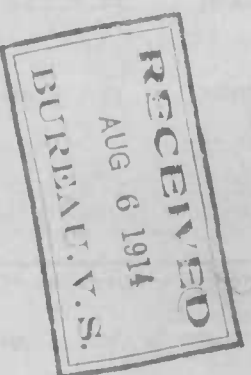
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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¹ PLACE OF DEATH Baltimore
County Baltimore

6508

(31)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 41

Village or City Canton (No. 1010, Bouldin St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME John Friese

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Male ⁴ COLOR OR RACE White ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

⁶ DATE OF BIRTH December 13, 1913
(Month) (Day) (Year)

⁷ AGE 7 yrs. 12 mos. 12 ds. IF LESS than 1 day, ____ hrs. OR ____ min. ?

⁸ OCCUPATION (a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Maryland

¹⁰ NAME OF FATHER Bert Friese

¹¹ BIRTHPLACE OF FATHER (State or country) Maryland

¹² MAIDEN NAME OF MOTHER Mary Schhardt

¹³ BIRTHPLACE OF MOTHER (State or country) Maryland

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bert Friese

(Address) 1010 Bouldin St.

¹⁵ Filed July 25, 1914 W. E. McClanahan
REGISTRAR W. E. Zickler + Zickler

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH July 24, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY that I attended deceased from July 23, 1914, to July 24, 1914
that I last saw him alive on July 24, 1914

and that death occurred on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Lesions

(Duration) 7 yrs. 12 mos. 12 ds.

Contributory Chronic Gastritis
Secondary

(Duration) 6 yrs. 6 mos. 6 ds.

(Signed) W. B. Tellow, M. D.

July 25, 1914 (Address) 3035 Odum Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL Trinity Cemetery

DATE OF BURIAL July 25, 1914

²⁰ UNDERTAKER W. E. Zickler + Zickler

ADDRESS 3204 O'Donnell

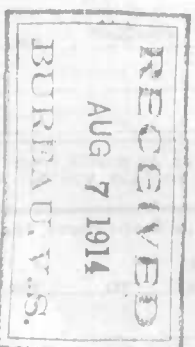
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Carcinoma" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County BaltimoreVillage or City Highlandtown (No. 701 S. Clinton St., St.; Ward)

2 FULL NAME

Wilhelmina B. GchoSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Oct. 1st, 1913
(Month) (Day) (Year)

7 AGE 9 yrs. 29 mos. 29 ds. OR 1 day, 29 hrs. 29 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Co.

PARENTS
10 NAME OF FATHER Addison Gcho
11 BIRTHPLACE OF FATHER (State or country) Baltimore Co.
12 MAIDEN NAME OF MOTHER Barbara Schnuff
13 BIRTHPLACE OF MOTHER (State or country) Baltimore City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Regd. W. E. M. Clavahan
Filed 1914 REGISTERED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 31st, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 15th, 1914 to July 31st, 1914
that I last saw her alive on July 30th, 1914

and that death occurred on the date stated above, at 4:15 P. m.
The CAUSE OF DEATH* was as follows:

Gastro-Enteritis
(Duration) 14 yrs. 14 mos. 14 ds.

Contributory
Secondary

(Signed) M. J. McAvay, M. D.
July 31st, 1914 (Address) 839 S. Ellwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 2 mos. 2 ds. In the State 1 yrs. 2 mos. 2 ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Aug. 2nd, 1914

20 UNDERTAKER W. E. M. Clavahan ADDRESS 403 S. Wolfe St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

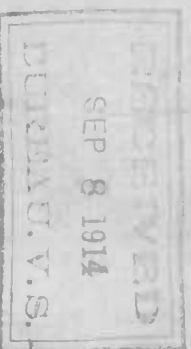
[Approved by U. S. Census and American Public Health Association.]

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| | | | | | |
|---|--|---|--|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 6512 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City _____ (No. <u>River View</u> St.; _____ Ward) | | Registration Dist. No. <u>41</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>Sophia Gensler</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u> | | | |
| 6 DATE OF BIRTH <u>May 25, 1879</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>35</u> yrs. <u>2</u> mos. <u>4</u> ds. If LESS than 1 day, _____ hrs. OR _____ min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>house work</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | | | | |
| 9 BIRTHPLACE (State or country) <u>Chicago</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Joseph Gensler</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Pa</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Mary Dinst</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Pa</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary R. Shank</u> (Address) <u>20 E. Chinn St</u> | | | | | |
| 15 FILED <u>July 19, 1914</u> <u>W.C. McClanahan</u> REGISTERED <u>Christian Miller</u> | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>July 19, 1914</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: | | | | | |
| <u>Drowning</u> (Duration) _____ yrs. _____ mos. _____ ds. | | | | | |
| Contributory Secondary <u>Boatley Point</u> <u>F.Y.B.</u> (Duration) _____ yrs. _____ mos. _____ ds. | | | | | |
| (Signed) <u>A. Warner</u> , M. D. <u>July 19, 1914</u> (Address) <u>Carson</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____ | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Greenmount Cemetery</u> DATE OF BURIAL <u>July 21, 1914</u> | | | | | |
| 20 UNDERTAKER <u>Christian Miller</u> ADDRESS <u>2334 Jefferson</u> | | | | | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6510

County

Baltimore

Village or City

Canton

(No. 930

S. Bouldin St.

Ward)

Registration Dist. No.

41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Catherine Gerlach

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

July 27, 1897

7 AGE

66 yrs. 11 mos. 16 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Germany

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER

(State or country)

Not known

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER

(State or country)

Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Valentine Gerlach

(Address)

930 S. Bouldin St.

15

Filed

July 13, 1914

W. E. McCauley

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 11, 1914

17

I HEREBY CERTIFY, that I attended deceased from

April 1914 to July 11, 1914

that I last saw her alive on July 10, 1914

and that death occurred on the date stated above, at 2300 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. 6 mos. ds.

Contributory Secondary

Edema of Lungs

(Duration) yrs. 2 mos. ds.

(Signed) J. B. Titlow, M. D.

July 11, 1914 (Address) 3035 O'Donnell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Carmel Cem.

July 14, 1914

20 UNDERTAKER

ADDRESS

Girkles + Girkles

3204 O'Donnell

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 7 1914

U. S. DEPT. OF COMMERCE

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH , 6511

County

Village or City

(No.

St.

Ward)

2 FULL NAME

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

Feb 28, 1877
(Month) (Day) (Year)

7 AGE

37 yrs. 16 mos. 16 ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Annapolis, Md.

10 NAME OF FATHER

Frank J. Gesner

11 BIRTHPLACE OF FATHER (State or country)

Balto, Md.

12 MAIDEN NAME OF MOTHER

Anna Clark

13 BIRTHPLACE OF MOTHER (State or country)

England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mother of patient

(Address)

15

Filed

July 16, 1914 overseer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 16, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from

June 1, 191B, to Oct 2, 191B.

that I last saw him alive on July 16, 1914

and that death occurred on the date stated above, at 3.05 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(Duration) 5 yrs. - mos. - ds.

Contributory Secondary

(Duration) None yrs. - mos. - ds.

(Signed) B. M. Bernhardt, M. D.

July 16, 1914 (Address) Baltimore, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 2 yrs. 6 mos. 8 ds. In the State 37 yrs. 4 mos. 16 ds.

Where was disease contracted, If not at place of death?

Former or usual residence Annapolis, Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Annapolis Md July 18 1914

20 UNDERTAKER

ADDRESS

W. J. Lickner 1000 York & Perry

If more blanks are needed, address State Registrar, 610 Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Baets

Village or City

Rossville

2 FULL NAME

Still born infant Elsie

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

m

4 COLOR OR RACE

*white*5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)*Single*

6 DATE OF BIRTH

July 8, 1914
(Month) (Day) (Year)

7 AGE

0 yrs. *0* mos. *0* ds. OR *1* day, *0* hrs. *0* min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

md

PARENTS

10 NAME OF FATHER

William Gleie

11 BIRTHPLACE OF FATHER

(State or country)

md

12 MAIDEN NAME OF MOTHER

Elij Marten

13 BIRTHPLACE OF MOTHER

(State or country)

md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Wm Gleie

(Address)

Rossville

15

Filed

July 8, 1914 J W Harsen

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

44

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

July 8, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw him alive on 191...

and that death occurred on the date stated above, at... m.

The CAUSE OF DEATH* was as follows:

*Still born**about 4 mos*

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

John W Harsen

M. D.

July 8, 1914 (Address) *McCall Run*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Gleie Farm**July 9, 1914*

20 UNDERTAKER

ADDRESS

*Father W Gleie**Rossville*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverter wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6514

County

Baltimore

Village or City

Highlandtown

(No.)

928 S. Third

Registration Dist. No.

41

St.; Ward)

[If death occurred in a hospital or institution, give its NAME Instead of street and number.]

2 FULL NAME

Marie E. Gutzinger.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

May 13th, 1913.
(Month) (Day) (Year)

7 AGE

1 yrs. 2 mos. 5 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Baltimore Co.

PARENTS

10 NAME OF FATHER

Bernard Gutzinger

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary Herbert.

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Gutzinger

(Address)

928 S. Third St.

15

Filed

July 19, 1914 H. W. W. Clavahan

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 18th, 1914.
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 12, 1914, to July 18, 1914.
that I last saw her alive on July 17, 1914.

and that death occurred on the date stated above, at 79. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) J. H. Collettier, M. D.

July 19, 1914. (Address) 1870 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Alphonsus Am. July 19th, 1914

20 UNDERTAKER

ADDRESS

Tilly & Ziehl 403 S. W. 1st St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

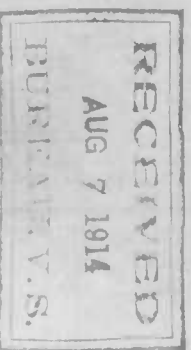
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculous* of *lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH Balto 6515

County

Village or City

Hundalk (No. _____)

St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Emil H. Goetzke

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Unknown

7 AGE

28

yrs.

mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Auctioneer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Unknown

PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur R. Goetzke

(Address)

2510 Roslyn Ave.

15

Filed

July 12, 1914

Registered

16 DATE OF DEATH

July 12, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Secondary

(Signed) J. H. Hapner, M. D.
July 12, 1914 (Address) Coroner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Wallbrook

DATE OF BURIAL

July 12, 1914

20 UNDERTAKER

Wm. J. Tickner

ADDRESS

North Ave.If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. J. Penn Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 7 1914

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Baltimore

6516

189

Village or City Benghis (No. _____ St. _____ Ward)

Registered No. 44

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Benjamin Franklin Graham Colver

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH unknown, 1 (Month) (Day) (Year)

7 AGE 70 yrs. 0 mos. 0 ds. If LESS than 1 day, hrs. OR min.

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore County

10 NAME OF FATHER Benjamin Graham

11 BIRTHPLACE OF FATHER (State or country) Balto County

12 MAIDEN NAME OF MOTHER Maria Graham

13 BIRTHPLACE OF MOTHER (State or country) Balto County

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Doc Wilmore

(Address) Benghis Balto & Md

15 Filed July 14, 1914 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him alive on _____, 191____,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

viewed the body & deemed urgent not necessary

unknown (Duration) yrs. mos. ds.

Contributory (Secondary) probably heart failure

(Signed) John A. Myers Corcoran, M. D.

July 14, 1914 (Address) Benghis

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sharp St DATE OF BURIAL July 16, 1914

20 UNDERTAKER Idace L Brown ADDRESS 105 No. Turkey

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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| | | | |
|---|---------------------------------|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> 6517 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Fullerton</u> (No. <u>28</u>) | | Registered No. <u>43</u> | |
| 2 FULL NAME <u>Franklin Theodore Grammer</u> | | (If death occurred in a hospital or institution, give its NAME instead of street and number.) | |
| PERSONAL AND STATISTICAL PARTICULARS | | MEDICAL CERTIFICATE OF DEATH | |
| 3 SEX <u>M.</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>Single</u> | 18 DATE OF DEATH <u>July 19, 1914</u> (Month) (Day) (Year) |
| 6 DATE OF BIRTH <u>Jan. 29th, 1871</u> (Month) (Day) (Year) | | 17 I HEREBY CERTIFY, That I attended deceased from <u>July 13</u> , 1914, to <u>July 19</u> , 1914, that I last saw him alive on <u>July 19th</u> , 1914, and that death occurred on the date stated above, at <u>1:30 P.</u> m. The CAUSE OF DEATH* was as follows: | |
| 7 AGE <u>43</u> yrs. <u>5</u> mos. <u>20</u> ds. OR <u>1</u> day, <u>1</u> hrs. <u>0</u> min. ? | | <u>Pulmonary Tuberculosis</u> (Duration) <u>2</u> yrs. <u>2</u> mos. <u>0</u> ds. | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Merchant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Selling groceries.</u> | | Contributory (Secondary) <u>Same</u> (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. | |
| 9 BIRTHPLACE (State or country) <u>Ind.</u> | | (Signed) <u>A. T. Milcison</u> , M. D. <u>7-20, 1914.</u> (Address) <u>Roseburg</u> | |
| 10 NAME OF FATHER <u>John Henry Grammer</u> | | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Ind.</u> | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, If not at place of death? Former or usual residence | |
| 12 MAIDEN NAME OF MOTHER <u>Catherine Emerson</u> | | 19 PLACE OF BURIAL OR REMOVAL <u>Hisco Court</u> | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> | | 20 UNDERTAKER <u>Geo. W. Grammer</u> | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Geo. Grammer</u> (Address) <u>Fullerton</u> | | DATE OF BURIAL <u>July 21, 1914</u> | |
| 15 Filed <u>July 22, 1914</u> <u>4 W. F. Clayton</u> REGISTRAR | | ADDRESS <u>Fullerton</u> | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH 6518

County BaltimoreVillage or City Edgemoor (No. 18, Daytona Crest; Ward)

2 FULL NAME

Laura Green.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 44

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH August 10, 1884
(Month) (Day) (Year)

7 AGE 30 yrs. 7 mos. 6 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. Laundress.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Pohatchen, Virg.

PARENTS
10 NAME OF FATHER I don't know.
11 BIRTHPLACE OF FATHER (State or country) I don't know.
12 MAIDEN NAME OF MOTHER Susanna Smith.
13 BIRTHPLACE OF MOTHER (State or country) Pohatchen Co., Virg.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Green.(Address) Edgemoor, Daytona Crest

15 July 18, 1914 G. H. McCombs
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1914, to July 17, 1914, that I last saw her alive on July 14, 1914

and that death occurred on the date stated above, at 8.15 a.m.
The CAUSE OF DEATH* was as follows:

Endocarditis.

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Frederick G. Hoenes, M. D.
July 18, 1914 (Address) 112 E. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asberry Cemetery July 19, 1914

20 UNDERTAKER

ADDRESS

Helix B. Rye 1026 Marlborough

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 6519
County Baltimore

Village or City Trenton (No. 19)

2 FULL NAME George Goefenstine

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 34

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male **4 COLOR OR RACE** white **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** (Write the word) married

6 DATE OF BIRTH 5 / 1 / 1830
(Month) (Day) (Year)

7 AGE 84 yrs. 1 mos. ds. **If LESS than** f day, hrs. **OR** min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Retired Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo A Wimer

(Address) Hampstead Md

15 Filed July 1 1914 C. E. Fowble M.D.
Local REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 / 1 / 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from for a number of years
that I last saw him alive on June 16, 1914

and that death occurred on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease
(mitral)

(Duration) 2 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo A Wimer, M. D.
(Address) Fowbleburg Inc

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Trenton **DATE OF BURIAL** July 1, 1914

20 UNDERTAKER C. V. Dutton & Son **ADDRESS** Hampstead Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Association.]

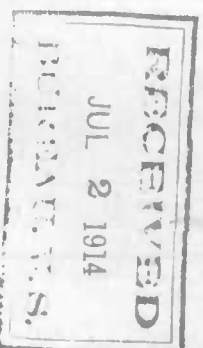
1 C 3 A -

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6520
County Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 32

Village or City Int. Washington (No. 79) Elderslie Ave St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Griffith, Richard Henry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH January 24, 1827
(Month) (Day) (Year)

7 AGE 87 yrs. 6 mos. 7 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Montgomery Co. Maryland

10 NAME OF FATHER Griffith, Richard Henry

11 BIRTHPLACE OF FATHER (State or country) Montgomery Co. Maryland

12 MAIDEN NAME OF MOTHER Magnolia, Mary

13 BIRTHPLACE OF MOTHER (State or country) Montgomery Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles P. Wolfe

(Address) Int. Washington, Md.

15 Filed July 31, 1914 William G. Queen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 31, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from September, 1913 to July 31, 1914

that I last saw him alive on July 31, 1914

and that death occurred on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Prutial insufficiency and
Aortic insufficiency
More than (Duration) 1 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Dr. Josiah S. Bowen, M.D.
July 31, 1914 (Address) Int. Washington, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Woodlark Park Aug 2, 1914

20 UNDERTAKER ADDRESS

Carl Mitchell 1201 N. Fayette

CERTIFICATE OF DEATH

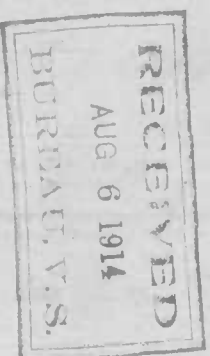
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **6521**
 County Baltimore **104**
 Village or City Thos. Wilson, Md. (No. Mr. Wilson, Md. Ward) **31**
 2 FULL NAME Evelyn Groves
 STATE OF MARYLAND
 CERTIFICATE OF DEATH
 Registration Dist. No. _____
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH Unknown
 (Month) (Day) (Year)

7 AGE 7 If LESS than 1 day, ____ hrs. ____ yrs. ____ mos. ____ ds. OR ____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Infant
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

PARENTS
 10 NAME OF FATHER Wm. Groves
 11 BIRTHPLACE OF FATHER (State or country) Unknown
 12 MAIDEN NAME OF MOTHER Unknown
 13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank J. Wilson
 (Address) Mr. Wilson, Md.

15 Filed 2, 191____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 21st, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw him alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Dis Colitis

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
 Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Frank J. Wilson, M. D.
July 21, 1914 (Address) Mr. Wilson, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, At home

If not at place of death? Baltimore

19 PLACE OF BURIAL OR REMOVAL Unknown DATE OF BURIAL _____, 191____

20 UNDERTAKER Unknown ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

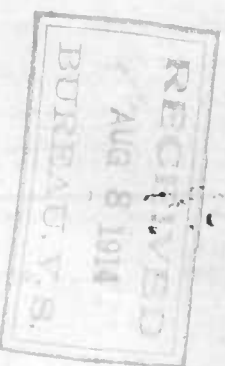
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-themia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6522

County

Balto.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

12 41

Village or City

12th Dist. (No. 5000 O'Donnell

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Michael Otis Gunnip

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

single

6 DATE OF BIRTH

Jan 30, 1914
(Month) (Day) (Year)

7 AGE

5 yrs. 1 mos. 1 ds. OR LESS than
1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Balto. Co. Md

PARENTS

10 NAME OF FATHER

Patrick J. Gunnip

11 BIRTHPLACE OF FATHER
(State or country)

Canada

12 MAIDEN NAME OF MOTHER

Katherine Adams

13 BIRTHPLACE OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant)

Katherine Gunnip

(Address)

5000 O'Donnell

15

Filed

July 1, 1914 W. S. McClanahan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 1, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
June 23, 1914, to July 1, 1914

that I last saw him alive on June 30, 1914

and that death occurred on the date stated above, at 3.40 m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) yrs. mos. 14 ds.

Contributory
Secondary

Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

(Signed)

M. J. McCarry, M. D.

July 1, 1914 (Address) 839 S. Ellwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Sacred Heart Cem. July 2nd, 1914

20 UNDERTAKER

Jelly W. Zeile. 4038 Wagon

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

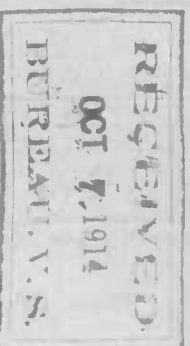
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthiness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial nephritis*; *Acute interstitial nephritis*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on nomenclature of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6523

County Balto.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Riverview (No. Beauty Beach St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Peter Hagan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Feb. 18, 1914
(Month) (Day) (Year)

7 AGE 5 yrs. 5 mos. 5 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto. Co. Md.

PARENTS
10 NAME OF FATHER Joseph B. Hagan
11 BIRTHPLACE OF FATHER (State or country) Balto. Md.
12 MAIDEN NAME OF MOTHER Magdalena Dziennik
13 BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph B. Hagan(Address) Beauty Beach Riverview

15 Filed July 20, 1914 W. E. M. Clarkson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 18, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1914, to July 19, 1914, that I last saw him alive on July 18, 1914

and that death occurred on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) yrs. mos. 7 ds.

Contributory Typhoid
Secondary

(Duration) about 36 hours
.... yrs. mos. ds.

(Signed) William L. Burke, M. D.

July 19, 1914 (Address) 3042 Haddon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Holy Cross Cemetery July 20, 1914

20 UNDERTAKER ADDRESS Lilly Zeier 403 S. Wolfe

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

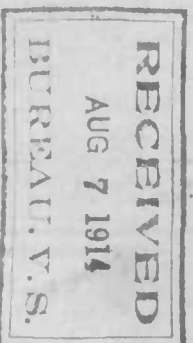
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

6524

County BaltimoreVillage or City St Agnes Hospital (No. _____)

St; _____ Ward)

Registration Dist. No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William Hardt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

Nov. 11, 1913
(Month) (Day) (Year)

7 AGE

8 yrs. 3 mos. 3 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Baltimore

PARENTS

10 NAME OF FATHER

John Hardt

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Marjorie Rich

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John Hardt(Address) 36 S Carey Street

15

Filed July 14, 1914 Guastavich
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 14, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 30, 1914, to July 14, 1914,
that I last saw him alive on July 14, 1914

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Multiple Myeloma
renal

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
SecondaryTuberculosis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Guastavich, M. D.July 14, 1914 (Address) St Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. 15 ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence 36 S Carey Street

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore AnnJuly 17, 1914

20 UNDERTAKER

ADDRESS

Wm J Snyder1600 W Nantonn

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

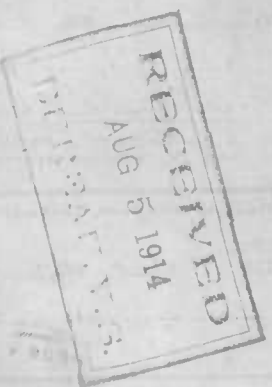
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

6525

County

Baltimore

Village or City

Leaonsville, Spring Grove S. H. - Ward

Registration Dist. No.

30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Alfred H. Harrington

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

ORDIVORCED

(Write the word)

Married

6 DATE OF BIRTH

May 22nd, 1846

(Month) (Day) (Year)

7 AGE

68 yrs. 1 mos. 27 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

James Harrington

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Harriet Moore

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Alf H. Harrington

(Address)

Baltimore

15

Filed

July 19, 1914 Marshall B. West

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 18th, 1914

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 12, 1914, to July 18th, 1914that I last saw him alive on July 18th, 1914

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Bright Disease

(Duration) yrs. 2 mos. ds.

Contributory (Secondary)

Renal Sclerosis

(Duration) yrs. mos. ds.

(Signed)

J. P. Wade, M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 2 mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or usual residence

Baltimore

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenwood Pk

July 21, 1914

20 UNDERTAKER

Geo. W. Fink

ADDRESS

214 Wolfe St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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RECEIVED

AUG 6 1914

BUREAU, U. S.

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| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH <u>6526</u> | | STATE OF MARYLAND | |
| County <u>Baltimore</u> | | CERTIFICATE OF DEATH | |
| Village or City <u>Near Reisterstown</u> (No.) St.; Ward | | Registration Dist. No. <u>53</u> | |
| 2 FULL NAME <u>Not named Still Born Harrison</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Still Born</u> | |
| 6 DATE OF BIRTH <u>July 26</u> , 191 <u>4</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>Still Born</u> | | If LESS than 1 day, hrs. yrs. mos. ds. OR min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) | | | |
| PARENTS | 10 NAME OF FATHER <u>Unknown</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Viola Harrison</u> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Aune Anndel Co. Md</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Elmer Harrison</u> (Address) <u>Reisterstown Md</u> | | | |
| 15 Filed <u>July 27</u> , 191 <u>4</u> <u>STMSlade</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>July 26</u> , 191 <u>4</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY That I attended deceased from 191....., to 191....., that I last saw h..... alive on..... 191..... and that death occurred on the date stated above, at m. The CAUSE OF DEATH* was as follows: <u>Still Born</u> (Duration) yrs. mos. ds. Contributory Secondary (Duration) yrs. mos. ds. (Signed) <u>STMSlade</u> , M. D. <u>July 27</u> , 191 <u>4</u> (Address) <u>Reisterstown Md</u> | | | |
| *State, the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence..... | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Near Reisterstown</u> | | DATE OF BURIAL <u>July 27</u> , 191 <u>4</u> | |
| 20 UNDERTAKER <u>None</u> | | ADDRESS | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

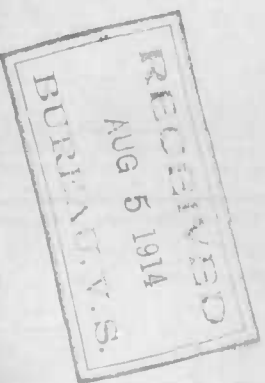
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH **6527**
County Baltimore

Village or City Mt Hope (No. Mt Hope Roman St.; 32 Ward)

2 FULL NAME Eduard Heil

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 22, 1895
(Month) (Day) (Year)

7 AGE 19 yrs. 0 mos. 7 ds. OR min. ?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Nurse
(b) General nature of industry, business, or establishment in which employed (or employer) Hospital Work

9 BIRTHPLACE (State or country) Phila Pa.

PARENTS
10 NAME OF FATHER Henry B. Heil
11 BIRTHPLACE OF FATHER (State or country) Pa
12 MAIDEN NAME OF MOTHER Margaret Langgood
13 BIRTHPLACE OF MOTHER (State or country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Records of Mt Hope Roman
(Address) Mt Hope Md.

15 Filed July 29, 1914 Wm J. Green
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 29, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 18th, 1914, to July 29th, 1914,
that I last saw h. 28th alive on July 28th, 1914,

and that death occurred on the date stated above, at 5:10 A. M.
The CAUSE OF DEATH* was as follows:

Acute Recurrent Nephritis

alt (Duration) 0 yrs. 0 mos. 21 ds.

Contributory Cardiac Lesion - Cardiac Symp.
Secondary

alt (Duration) 0 yrs. 0 mos. 1/2 ds.

(Signed) Frank J. Flannery, M. D.
July 29, 1914 (Address) Frank J. Flannery

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death 0 yrs. 0 mos. 10 ds. In the West River State 0 yrs. 0 mos. 0 ds.
Where was disease contracted, Norfolk Va
If not at place of death?
Former or usual residence Baltimore Md.

19 PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL July 31, 1914

20 UNDERTAKER Wm M. Gauthier ADDRESS 903 North St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

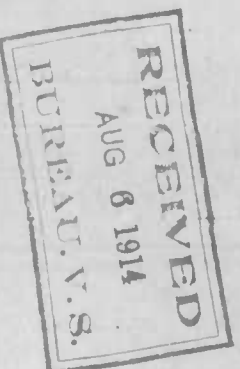
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH **6528**
County **Baltimore**

Village or City **Lansdowne** (No. **104**)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. **42**

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME **Young John Helwig**

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **male** 4 COLOR OR RACE **White** 5 SINGLE, **Infant**
~~MARRIED,~~
~~WIDOWED,~~
~~OR DIVORCED~~
(Write the word)

6 DATE OF BIRTH **January 13, 1914**
(Month) (Day) (Year)

7 AGE **6 mos. 13 ds.** If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work **Infant**
(b) General nature of industry, business, or establishment in which employed (or employer) **" "**

9 BIRTHPLACE (State or country) **Belt Co. Md**

PARENTS
10 NAME OF FATHER **Harry H. Helwig**
11 BIRTHPLACE OF FATHER (State or country) **Belt Co. Md**
12 MAIDEN NAME OF MOTHER **Catherin C. Lesner**
13 BIRTHPLACE OF MOTHER (State or country) **Baltimore Md**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Catherin Helwig**
(Address) **Lansdowne Balt Co Md**

15 Filed **July 26, 1914** **Frank H. Ruhl**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **July 25th, 1914**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **July 24, 1914**, to **July 25, 1914**,
that I last saw him alive on **July 25, 1914**

and that death occurred on the date stated above, at **11:05 p.m.**
The CAUSE OF DEATH* was as follows:

Summer Brain Fever
(Duration) yrs. mos. **4** ds.
Contributory **Convulsions**
Secondary

(Signed) **Frank H. Ruhl**, M. D.
July 26, 1914 (Address) **Lansdowne Md**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL **German Ev. Lutheran Cemetery, Balt** DATE OF BURIAL **July 27, 1914**
1202 F St

20 UNDERTAKER **A. Jones** ADDRESS **207 S. Shattuck St**

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

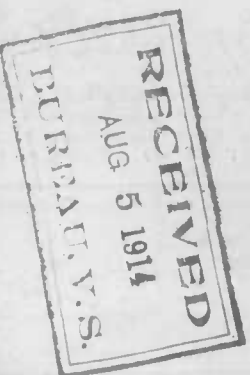
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH **6529**
County Baltimore

Village or City Lanaville, Hartford Road El Mark, Ave (Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Amelia Hill

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 8 3, 1868
(Month) (Day) (Year)

7 AGE 46 yrs. 11 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Geo H C Sack

11 BIRTHPLACE OF FATHER (State or country) Europe

12 MAIDEN NAME OF MOTHER Beatty Raw

13 BIRTHPLACE OF MOTHER (State or country) Europe

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Beatty Sack

(Address) Lanaville Md.

15 Filed 7/28, 1914 Clara Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH 7 26, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 9, 1914, to June 5, 1914, that I last saw him alive on June 24, 1914

and that death occurred on the date stated above, at 7:30 a.m.
The CAUSE OF DEATH* was as follows:

Myocardial Regurgitation

(Duration) unknown yrs. mos. ds.

Contributory B. chronic
Secondary Myocarditis

(Duration) unknown yrs. mos. ds.

(Signed) Clara Smith, M. D.

July 27, 1914. (Address) Lanaville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death unknown yrs. unknown mos. unknown ds. In the State unknown yrs. unknown mos. unknown ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Jerusalem Cemetery DATE OF BURIAL July 28, 1914

20 UNDERTAKER Fred. Sack ADDRESS Fullerton Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

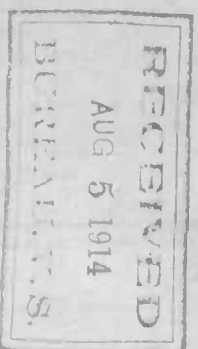
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH Balto Co. 6530

County Balto Co. Village or City West Baltimore (No. 151)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Howard N. Hinks

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX Male 4 COLOR OR RACE Wh 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

6 DATE OF BIRTH June 29, 1914
(Month) (Day) (Year)

7 AGE 29 yrs. 0 mos. 0 ds. If LESS than 1 day, hrs. 0 min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Co Md

10 NAME OF FATHER John T. Hinks

11 BIRTHPLACE OF FATHER (State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Julia Davis

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. T. Hinks

(Address) Balto. Co Md

15 Filed July 22, 1914 J. T. Hinks
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 22, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 7-19, 1914, to 7-21, 1914.

that I last saw him alive on 7-21, 1914.

and that death occurred on the date stated above, at 3-9 m.

The CAUSE OF DEATH* was as follows:

Thromb embolism

(Duration) 0 yrs. 0 mos. 0 ds.

Contributory exhaustion
Secondary

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) W. B. Hance, M. D.

7-22, 1914. (Address) West Minors

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St Paul's Luth Church DATE OF BURIAL July 23, 1914

20 UNDERTAKER Mrs. A. Rohde ADDRESS 730 Pa Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as—*Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH **6531**
County Baltimore

Village or City Mt Hope (No. 141 Hope Rd St.; 2 Ward)

2 FULL NAME Frances A HoltonSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Don't Know, 1_____, 1_____
(Month) (Day) (Year)

7 AGE abt 63 yrs. 0 mos. 0 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE

(State or country) Don't KnowPARENTS
10 NAME OF FATHERDon't Know11 BIRTHPLACE OF FATHER
(State or country)Don't Know

12 MAIDEN NAME OF MOTHER

Don't Know13 BIRTHPLACE OF MOTHER
(State or country)Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Records of Mt Hope Rd(Address) Mt Hope Md

15 July 25, 1914 Wm. J. Queen
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 25, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mon 1st, 1911, to July 25, 1914.

that I last saw her alive on July 24, 1914.

and that death occurred on the date stated above, at 1:50 p.m.

The CAUSE OF DEATH* was as follows:

Mania Chronic

abt (Duration) 14 yrs. 0 mos. 0 ds.

Contributory Ex Chr. Nephritis
Secondary Hypertensive Congest

(Signed) Frank J. Flannery, M. D.

July 25, 1914 (Address) Mt Hope Rd

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 13 yrs. 0 mos. 0 ds. In the Life State _____ yrs. _____ mos. _____ ds

Where was disease contracted, Arlington Md

If not at place of death? _____
Former or usual residence Arlington Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonnie BaeJuly, 1914

20 UNDERTAKER

ADDRESS

Stewart Moran Co 1520 English

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs, meningis, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 6 1914
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | | |
|---|---|---|--|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 6532 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City | | (No. <u>8</u>) | | Registration Dist. No. <u>31</u> | |
| 2 FULL NAME <u>Eliz. Home</u> | | St. <u>Wm. Wilson</u> Ward | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>Black</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | | | |
| 6 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>4</u> yrs. <u>4</u> mos. <u>4</u> ds. If LESS than 1 day, hrs. OR min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Baltimore</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Unknown</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm. Wilson</u> (Address) <u>Wm. Wilson, Ind.</u> | | | | | |
| 15 | | | | | |
| 16 DATE OF DEATH <u>July 12th, 1914</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from, 191....., to 191..... that I last saw him alive on 191..... and that death occurred on the date stated above, at m. The CAUSE OF DEATH* was as follows: <u>Whooping Cough</u> (Duration) yrs. mos. ds. Contributory <u>malnutrition</u> Secondary (Duration) yrs. mos. ds. (Signed) <u>Wm. Wilson</u> , M. D. <u>July 12, 1914</u> (Address) <u>Wm. Wilson</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. <u>9</u> ds. In the State yrs. mos. ds. Where was disease contracted, <u>at home</u> If not at place of death? Former or usual residence <u>Baltimore</u> | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Unknown</u> DATE OF BURIAL 191..... | | | | | |
| 20 UNDERTAKER <u>Unknown</u> ADDRESS | | | | | |

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

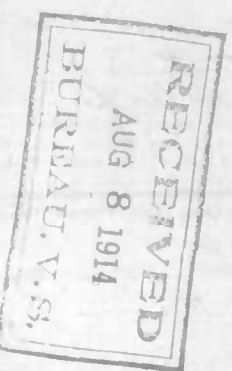
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1 PLACE OF DEATH 6533
 County Balto.
 Village or City Westport (No. CD 104) St.; Ward) [It death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME Ethel May Hood
 Registration Dist. No. 402

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH July 13th, 1914
 (Month) (Day) (Year)

7 AGE 17 yrs. — mos. 15 ds. If LESS than 1 day... hrs. OR... min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Westport, Balto.

PARENTS

10 NAME OF FATHER Mr Hood
 11 BIRTHPLACE OF FATHER (State or country) Anne Arundel Co.
 12 MAIDEN NAME OF MOTHER Caroline Brown
 13 BIRTHPLACE OF MOTHER (State or country) Anne Arundel Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Caroline Hood.
 (Address) Westport, Md.

15 July 24, 1914
 Filed F. H. Riehl
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 24, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1914 to 1914

that I last saw h. alive on 1914

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Auto Intoxication
 (Duration) — yrs. — mos. — ds.

Contributory Secondary (Duration) — yrs. — mos. — ds.

(Signed) Chas. Hull, Coroner, Md. Westport, 1914 (Address) Mt Airman, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Olden Hill Memorial Ch. DATE OF BURIAL July 20, 1914

20 UNDERTAKER J. Tucker Son ADDRESS Balto Md

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1 PLACE OF DEATH

6534

County

Baltimore

Village or City

St. Agnes Hospital

(No.)

Registration Dist. No.

42.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles A. Hook

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Aug. 2, 1874
(Month) (Day) (Year)

7 AGE

42 yrs. 11 mos. 14 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Box maker

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore, Md.

PARENTS

10 NAME OF FATHER

Samuel R. Hook

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Kuhn

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Samuel R. Hook

(Address)

2130 Bay St.

15

Filed July 16, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 16, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY That I attended deceased from

July 13, 1914 to July 16, 1914
that I last saw him alive on July 16, 1914

and that death occurred on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. mos. ds.

Contributory
Secondary

Tarama

Cardiac Failure (Duration) yrs. mos. ds.

(Signed)

Geo. A. Stewart

, M. D.

July 16, 1914 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

2130 Bay St.

19 PLACE OF BURIAL OR REMOVAL

Mt. O. Grubben

DATE OF BURIAL

July 20, 1914

20 UNDERTAKER

Wm. Cook

ADDRESS

528 North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

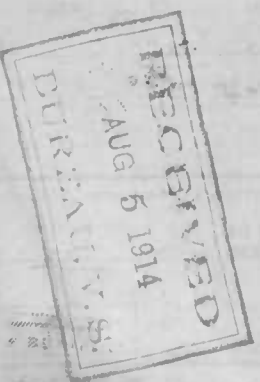
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as *As-thenia*, "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH **6535**
County **Baltimore**

Village or City **Chesolance** (No. **92**) St; Ward

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. **32**

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME **Annett D. Hopkins**

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **White** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED **Married**
(Write the word)

6 DATE OF BIRTH **11 22 1846**
(Month) (Day) (Year)

7 AGE **68** yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work **Lady**
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) **New Jersey**

10 NAME OF FATHER **John E. Hopkins**

11 BIRTHPLACE OF FATHER (State or country) **New Jersey**

12 MAIDEN NAME OF MOTHER **Antonek Hicks**

13 BIRTHPLACE OF MOTHER (State or country) **New York**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Sas. Hopkins**

(Address) **Chesolance**

15 **July 25 1914** **Henry G. Taylor**
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **July 24 1914**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **July 22**, 1914, to **July 24**, 1914, that I last saw her alive on **July 23**, 1914

and that death occurred on the date stated above, at **2.30** p. m.
The CAUSE OF DEATH* was as follows:

Paralysis (Duration) **10** yrs. mos. ds.

Contributory (Secondary) **Pneumonia** (Duration) **2** yrs. mos. ds.

(Signed) **W. H. Barry**, M. D.
July 25, 1914. (Address) **Cornell Mills**

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL **St. Thomas** DATE OF BURIAL **July 26 1914**

20 UNDERTAKER **C. H. Kraft** ADDRESS **Pikesville**

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

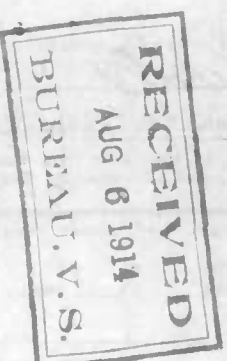
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mebles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **6536**
 County Balto
 Village or City Colgate Creek (No. 169) St.; Ward 41
 2 FULL NAME Walter S. Horst

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
 4 COLOR OR RACE W
 5 SINGLE, single
 MARRIED,
 WIDOWED,
 OR DIVORCED
 (Write the word)
 6 DATE OF BIRTH July 1 1888
 (Month) (Day) (Year)
 7 AGE 26 yrs. 16 mos. 16 ds. OR LESS than 1 day.....hrs. OR.....min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Printer
 (b) General nature of industry, business, or establishment in which employed (or employer) -

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Conrad Horst
 11 BIRTHPLACE OF FATHER (State or country) Germany
 12 MAIDEN NAME OF MOTHER Christina Hoerringer
 13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Edward Horst
 (Address) 3302 Faith Ave

15 Filed July 19, 1914 W. E. McClanahan
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

accidental drowning
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 Secondary

(Signed) A. S. McNeill, M. D.
July 18, 1914 (Address) Coroner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence 437 S. Robinson St

19 PLACE OF BURIAL OR REMOVAL McNeill DATE OF BURIAL July 21, 1914

20 UNDERTAKER W. E. McClanahan ADDRESS 1710 Fleet St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 7 1914

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | | |
|---|---|--|--|---|--|
| 1 PLACE OF DEATH <i>Balto.</i> | | 6537 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <i>Balto.</i> | | (64) | | Registration Dist. No. <i>40</i> | |
| Village or City <i>Kingenille</i> (No. _____) | | St. _____ | | Ward _____ | |
| 2 FULL NAME <i>Gilpin O. Hutton</i> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <i>Male</i> | 4 COLOR OR RACE <i>White</i> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Childless</i> | | | |
| 6 DATE OF BIRTH <i>Oct 3, 1847</i> (Month) (Day) (Year) | | | | | |
| 7 AGE <i>66 yrs 9 mos 24 ds.</i> If LESS than 1 day, ____ hrs. OR ____ min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>None</i> (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | | | | |
| 9 BIRTHPLACE (State or country) <i>Lancaster Pa.</i> | | | | | |
| PARENTS | 10 NAME OF FATHER <i>Bickett Hutton</i> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <i>Unknown</i> | | | | |
| | 12 MAIDEN NAME OF MOTHER <i>Elizabeth M. Howell</i> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <i>Unknown</i> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>L. L. Dilworth</i> (Address) <i>Kingenille Md.</i> | | | | | |
| 15 FILED <i>July 29, 1914</i> <i>L. F. H. Gersmehl</i> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <i>July 27, 1914</i> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <i>Apr</i> , 1907, to <i>July 27</i> , 1914, that I last saw him alive on <i>July 27</i> , 1914, and that death occurred on the date stated above, at <i>140 P. m.</i> | | | | | |
| The CAUSE OF DEATH* was as follows: <i>apoplexy Apr 1907 followed by tamponade of brain of an artery in the brain (Duration) 7 yrs 3 mos.</i> Contributory <i>Sclerosis of arteries (Duration) 7 yrs 3 mos.</i> (Signed) <i>L. F. H. Gersmehl</i> , M. D. <i>Fork Md July 29 1914</i> (Address) <i>Fork Md.</i> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____ | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <i>St Johns Cem. Kingmill Md</i> DATE OF BURIAL <i>July 30, 1914</i> | | | | | |
| 20 UNDERTAKER <i>John Arthur Houn</i> ADDRESS <i>Fork, Md.</i> | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH

6538

County

Baltimore

Village or City

Dundalk

(No.)

Registration Dist. No.

41

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Celie Hymans

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

unknown

7 AGE

17

yrs. mos. ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

sales girl

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Louis Hymans

11 BIRTHPLACE OF FATHER (State or country)

Russia

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (State or country)

Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Erwin Hymans

(Address)

2358 McCallah

15

Filed

July 13, 1914

REGISTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 12, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY That I attended deceased from

191

to

191

that I last saw him alive on

191

and that death occurred on the date stated above, at

m.

The CAUSE OF DEATH* was as follows:

Drowning

Accident

F.V.P.

(Duration) yrs. mos. ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

J. H. Hymans, M. D.

July 13, 1914 (Address) coroner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebrew Rose dal

July 14, 1914

20 UNDERTAKER

ADDRESS

Jack Lewis

1419 E. B. Rd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

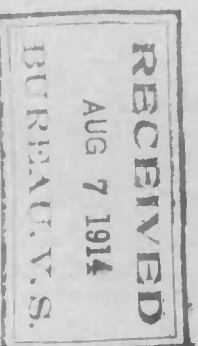
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

6539

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Canton

(No. 332,

P. Boulton

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Still Birt

6 or 7 months before

Jacobs

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

July 13, 1914
(Month) (Day) (Year)

7 AGE

Still Birt

If LESS than
1 day, hrs.
yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

none

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Balt. County

PARENTS

10 NAME OF
FATHER

Jacob Jacobs

11 BIRTHPLACE
OF FATHER
(State or country)

Md

12 MAIDEN NAME
OF MOTHER

Sophia Eymers

13 BIRTHPLACE
OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elizabeth Jacobs

(Address)

13651 O'Donnell Rd

15

Filed

July 4, 1914 W.E. McLaughlin

REGISTRAR

16 DATE OF DEATH

July 13, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on July 13, 1914

and that death occurred on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Still Birt

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

W. Jones

, M. D.

July 3, 1914 (Address) 3116 O'Donnell Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Mt. Carmel Cem.

DATE OF BURIAL

July 4, 1914

20 UNDERTAKER

Gahler & Gahler

ADDRESS

3204 O'Donnell

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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RECEIVED
JUL 7 1914
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | | |
|---|--|---|--|---|--|
| 1 PLACE OF DEATH County <u>Balto</u> | | 8540 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Ruststown</u> (No. <u>41</u>) | | <u>MD</u> | | Registration Dist. No. <u>23</u> | |
| 2 FULL NAME <u>Sarah E. Joseph</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | | | |
| 6 DATE OF BIRTH <u>Aug 1</u> , 18 <u>39</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>79</u> yrs. <u>11</u> mos. <u>5</u> ds. OR <u>LESS</u> than 1 day, _____ hrs. OR _____ min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | | | | |
| 9 BIRTHPLACE (State or country) <u>Balto to MD</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Romanic B. Joseph</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Ann Prings</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. William Prings</u> (Address) <u>Ruststown MD</u> | | | | | |
| 15 Filed <u>July 7, 1914</u> <u>10:00</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>July 6</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Feb. 1</u> , 191 <u>4</u> , to <u>July 6</u> , 191 <u>4</u> , that I last saw her alive on <u>July 6</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>1 P</u> m. | | | | | |
| The CAUSE OF DEATH* was as follows: <u>Carcinoma of Colon</u> (Duration) _____ yrs. <u>8</u> mos. _____ ds. | | | | | |
| Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. | | | | | |
| (Signed) <u>Dr. Wm. B. ...</u> , M. D. <u>July 7</u> , 191 <u>4</u> (Address) <u>Ruststown</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____ | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Ruststown MD</u> DATE OF BURIAL <u>July 8</u> , 191 <u>4</u> | | | | | |
| 20 UNDERTAKER <u>J. F. Eline</u> ADDRESS <u>Ruststown MD</u> | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | |
|--|--|--|--|---|---|
| 1 PLACE OF DEATH County <u>Balto</u> | | 6541 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Rosedale</u> (No. <u>71</u>) | | St. _____ Ward _____ | | Registered No. <u>43</u> | |
| 2 FULL NAME <u>John Kahler</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>Single</u> | | | |
| 6 DATE OF BIRTH <u>July 3</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | | |
| 7 AGE _____ yrs. _____ mos. <u>1</u> ds. | | If LESS than 1 day, _____ hrs. OR _____ min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u> | | | | | |
| 9 BIRTHPLACE (State or country) <u>Rosedale</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>John Kahler</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Rosedale</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Anne Toeffler</u> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Baltimore</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Kahler</u> (Address) <u>Rosedale Md</u> | | | | | |
| 15 Filed <u>July 4, 1914</u> <u>H. F. Clayton</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>July 4</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>July 3</u> , 191 <u>4</u> , to <u>July 4</u> , 191 <u>4</u> , that I last saw him <u>live</u> on <u>July 3</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>5</u> a. m., The CAUSE OF DEATH* was as follows: <u>convulsions</u> | | | | | |
| (Duration) _____ yrs. _____ mos. _____ ds. | | | | | |
| Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds. | | | | | |
| (Signed) <u>Wm D. Corse</u> , M. D. <u>July 4</u> , 191 <u>4</u> (Address) <u>Baltimore Md</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____ | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Holy Redeemer</u> | | | | | DATE OF BURIAL <u>July 4</u> , 191 <u>4</u> |
| 20 UNDERTAKER <u>Chas W Lantz</u> | | | | | ADDRESS <u>Rosedale Md</u> |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6542

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

12

Village or City

Highlandtown (No. 37, 31 Eastern ave.)

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

George Henry Keil

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

June 6, 1873
(Month) (Day) (Year)

7 AGE

41 yrs. 1 mos. ds. OR LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Driver (Brewery)

(b) General nature of industry, business, or establishment in which employed (or employer)

Brewery

9 BIRTHPLACE
(State or country)

Md

PARENTS

10 NAME OF FATHER

George Henry Keil

11 BIRTHPLACE OF FATHER
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER
(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Kate Keil

(Address)

3731 Eastern ave

15

Filed

July 7, 1914

W. E. McLaughlin

REGISTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 6, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 22, 1914, to July 6, 1914,
that I last saw him alive on July 5, 1914and that death occurred on the date stated above, at 2. d. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 10 ds.

Contributory
(Secondary)

Dilated heart

(Duration) yrs. mos. 2 ds.

(Signed)

M. J. McLaughlin, M. D.

July 7, 1914 (Address) 839 S. Ellwood ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Schwartz

July 9, 1914

20 UNDERTAKER

ADDRESS

Wm. Cook

504 E. North

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 7 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | |
|--|--|--|--|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 5543 <u>104</u> | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City _____ (No. _____) | | Thos. Wilson <u>Sanctuary</u> | | Registration Dist. No. <u>31</u> | |
| 2 FULL NAME <u>Margaret Kidwell</u> | | St. _____ Ward | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>X</u> | | | |
| 6 DATE OF BIRTH <u>Unknown</u> | | (Month) _____ (Day) _____ (Year) _____ | | | |
| 7 AGE <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds. OR <u>1</u> day, _____ hrs. _____ min. ? | | 16 DATE OF DEATH <u>July 11th, 1914</u> (Month) _____ (Day) _____ (Year) _____ | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Infant</u> | | 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h. _____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Gastro Intes Distraction</u> | | | |
| 9 BIRTHPLACE (State or country) <u>Baltimore, Md.</u> | | Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. | | | |
| PARENTS | 10 NAME OF FATHER <u>Unknown</u> | (Signed) <u>John Knox Jr.</u> , M. D. <u>July 11, 1914</u> (Address) <u>Int. Wilson</u> | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Margaret Kidwell</u> | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. <u>1</u> da. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? <u>As home</u> Former or usual residence <u>Baltimore</u> | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> | 19 PLACE OF BURIAL OR REMOVAL <u>Unknown</u> DATE OF BURIAL _____, 191____ | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Knox Jr.</u> (Address) <u>Int. Wilson, Md.</u> | | 20 UNDERTAKER <u>Unknown</u> ADDRESS _____ | | | |
| 15 Filed _____, 191____ | | REGISTRAR | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

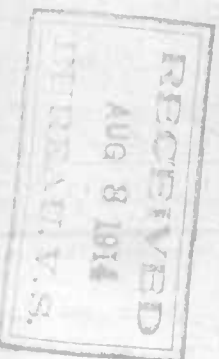
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *GROCERY*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH 6544 | | STATE OF MARYLAND | |
| County Baltimore | | CERTIFICATE OF DEATH | |
| Village or City (No. 104) Mrs. Wilson, Md. | | Registration Dist. No. 31 | |
| 2 FULL NAME Edw. Knofski | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX Male | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) S | |
| 6 DATE OF BIRTH Unknown (Month) (Day) (Year) | | | |
| 7 AGE 20 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work Infant (b) General nature of Industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) Baltimore | | | |
| PARENTS | 10 NAME OF FATHER Charles Knofski | | |
| | 11 BIRTHPLACE OF FATHER (State or country) Unknown | | |
| | 12 MAIDEN NAME OF MOTHER Unknown | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) Unknown | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. M. Knofski Jr. (Address) Mrs. Wilson, Md. | | | |
| 15 | | | |
| 16 DATE OF DEATH July 25th, 1914 (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from 191 , to 191 , that I last saw him alive on 191 , and that death occurred on the date stated above, at m. The CAUSE OF DEATH* was as follows: Ileus Colitis (Duration) yrs. mos. ds. 21 Contributory Nephritis Secondary (Duration) yrs. mos. ds. 10 (Signed) John Knofski Jr. , M. D. July 25, 1914 (Address) Mrs. Wilson, Md. | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. 10 In the State yrs. mos. ds. 10 Where was disease contracted, at home If not at place of death? Former or usual residence Baltimore | | | |
| 19 PLACE OF BURIAL OR REMOVAL Unknown | | DATE OF BURIAL 191 | |
| 20 UNDERTAKER Unknown | | ADDRESS | |
| REGISTRAR | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

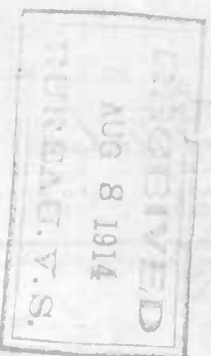
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

County Balto.Village or City Highlandtown (No. 3702 E. Pratt St.; Ward)

2 FULL NAME

John Koll.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Jan 16, 1910
(Month) (Day) (Year)

7 AGE 4 yrs. 5 mos. 29 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Co. Md.

10 NAME OF FATHER Joseph A. Koll.

11 BIRTHPLACE OF FATHER (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Bast.

13 BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph A. Koll.(Address) 3702 E. Pratt St.

15 Filed July 16, 1914 W. E. McLaughlin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 15, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1914 to July 15, 1914
that I last saw him alive on July 15, 1914

and that death occurred on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion
mitral insufficiency.

Contributory (Duration) X yrs. X mos. 3 ds.
Secondary Laryngeal Diphtheria

(Signed) Jan L. Drux, M. D.
July 15, 1914 (Address) 248 So Third

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sacred Heart Cemetery July 16, 1914

20 UNDERTAKER ADDRESS

Lilly Zeiler 403 S. Wolfe St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

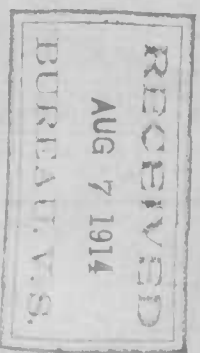
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| 1 PLACE OF DEATH | | 6546 | | 28 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|--|--|---|--|-------------------------------------|--|---|--|
| County <u>Balto.</u> | | Village or City <u>Hightstown</u> | | (No. <u>3829</u> <u>Front Ave</u>) | | Registered No. <u>41</u> | |
| 2 FULL NAME <u>Cornie Miller</u> | | [It death occurred in a hospital or institution, give its NAME instead of street and number.] | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u> | | | | | |
| 6 DATE OF BIRTH <u>Not known</u> | | (Month) (Day) (Year) | | | | | |
| 7 AGE <u>24</u> yrs. mos. ds. | | If LESS than 1 day, hrs. min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) | | <u>Housewife</u> | | | | | |
| 9 BIRTHPLACE (State or country) | | <u>Pennsylvania</u> | | | | | |
| PARENTS | 10 NAME OF FATHER | <u>John Benko</u> | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) | <u>Curtina</u> | | | | | |
| | 12 MAIDEN NAME OF MOTHER | <u>Helena Benko</u> | | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) | <u>Curtina</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | | | |
| (Informant) <u>John Benko</u> | | (Address) <u>3829 Front Ave</u> | | | | | |
| 15 Filed <u>July 14, 1914</u> | | REGISTRY <u>W. H. Clark</u> | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | |
| 16 DATE OF DEATH <u>July 12, 1914</u> | | (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Sept 1, 1913</u> to <u>July 12, 1914</u> | | that I last saw her alive on <u>July 12, 1914</u> | | | | | |
| and that death occurred on the date stated above, at <u>12:30 P.M.</u> | | The CAUSE OF DEATH* was as follows: | | | | | |
| <u>Tuberculosis of Lungs</u> | | (Duration) <u>1</u> yrs. mos. ds. | | | | | |
| Contributory (Secondary) <u>Toxemia</u> | | (Duration) <u>1</u> yrs. mos. ds. | | | | | |
| (Signed) <u>A. D. Titlow</u> | | M. D. <u>July 12, 1914</u> (Address) <u>3035 O'Donnell St.</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | |
| 16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | | | |
| At place of death | | yrs. mos. ds. | | In the State | | yrs. mos. ds. | |
| Where was disease contracted, If not at place of death? | | | | | | | |
| Former or usual residence | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Holy Redeemer</u> | | | | DATE OF BURIAL <u>July 15, 1914</u> | | | |
| 20 UNDERTAKER <u>W. H. Clark</u> | | | | ADDRESS <u>1904-6 Eastland Ave</u> | | | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not definitely employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name or origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary). 10 ds. Never report mere symptoms or terminal conditions, such as "Asplenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. It is impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 7 1914

BUREAU V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6547

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

42

Village or City

Landsdown

(No.

Glyde Ave

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Josephine A. Kramer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Married

6 DATE OF BIRTH

Oct 27, 1852
(Month) (Day) (Year)

7 AGE

61 yrs. 9 mos. c ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Philadelphia, Pa.

PARENTS

10 NAME OF FATHER

Robert Steinmetz

11 BIRTHPLACE OF FATHER (State or country)

Philadelphia

12 MAIDEN NAME OF MOTHER

Josephine Kern

13 BIRTHPLACE OF MOTHER (State or country)

Philadelphia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leop. E. Kramer

(Address)

Glyde Ave Landsdown

15

Filed

July 26, 1914 F. H. Ruhl

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 26, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 2, 1914, to July 26, 1914,

that I last saw him alive on July 25, 1914,

and that death occurred on the date stated above, at 8:20 A. M.

The CAUSE OF DEATH* was as follows:

Failure of the
Stomach

(Duration) yrs. 4 mos. — ds.

Contributory
Secondary

Larynx

(Duration) yrs. — mos. 4 ds.

(Signed)

R. G. Lamm

M. D.

July 26, 1914. (Address) Not known

14 *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

16 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Linden Park Cemetery July 29, 1914

20 UNDERTAKER

ADDRESS

Jas. J. Anderson, Son 217 S. Pine

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

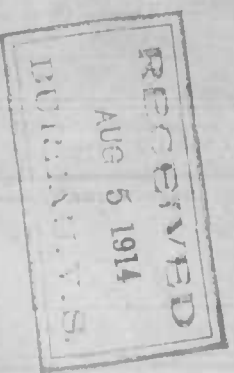
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Tailor—Gentling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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PLACE OF DEATH 6548

County

Balto

Village or City

Highlandtown

(No.)

3929 E Pratt St

Registration Dist. No.

46

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Margaret E. Kroll

PERSONAL AND STATISTICAL PARTICULARS

SEX

F

COLOR OR RACE

W.

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

DATE OF BIRTH

May

(Month)

8

(Day)

1914

(Year)

AGE

7 yrs. 7 mos. ds.

If LESS than 1 day, hrs. OR min. ?

OCCUPATION

(a) Trade, profession, or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country)

Balto

PARENTS

NAME OF FATHER

Oskar Kroll

BIRTHPLACE OF FATHER (State or country)

Germania

MAIDEN NAME OF MOTHER

Anna Friedrich

BIRTHPLACE OF MOTHER (State or country)

Germania

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anna Kroll

(Address)

3929 E Pratt St

FILED

July 1, 1914

W. E. McLaughlin

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

July 1

(Month)

(Day)

1914

I HEREBY CERTIFY, That I attended deceased from

June 23

1914

to

July 1

1914

that I last saw her alive on

June 30

1914

and that death occurred on the date stated above, at 2:15 p. m.

The CAUSE OF DEATH* was as follows:

Impetigo

(Duration)

yrs.

mos.

14 ds.

Contributory (Secondary)

Phagedenic ulcer of

chest, (Gonorrhea)

(Duration)

yrs.

mos.

7 ds.

(Signed)

M. J. McCauley, M. D.

July 1, 1914

(Address)

839 S. Ellwood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or

usual residence.

PLACE OF BURIAL OR REMOVAL

Trinity Cem

DATE OF BURIAL

July 2, 1914

UNDERTAKER

Wm Cook

ADDRESS

605 E North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

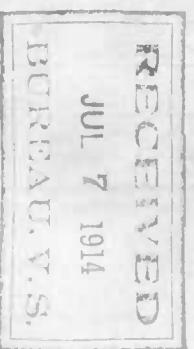
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septi-cemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH Balto 6549 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County Balto | | Registration Dist. No. 444 | |
| Village or City Sparrows Point (No. 27 , Baltimore St.; Ward) | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME still born infant Kuteah | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX undetermined | 4 COLOR OR RACE W | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single (Write the word) | |
| 6 DATE OF BIRTH July 7th, 1914 (Month) (Day) (Year) | | | |
| 7 AGE 1 LESS than 1 day, hrs. yrs. mos. ds. OR ma? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer) none | | | |
| 9 BIRTHPLACE (State or country) Sparrows Point Md | | | |
| PARENTS | 10 NAME OF FATHER Eli Kuteah | | |
| | 11 BIRTHPLACE OF FATHER (State or country) Austria | | |
| | 12 MAIDEN NAME OF MOTHER Esther Busch | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) Austria | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Eli Kuteah (Address) Sparrows Point Md | | | |
| 15 Filed July 8th, 1914 G. F. McCormick M.D. REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH July 7th, 1914 (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from 1914 to 1914 , that I last saw him alive on 1914 , and that death occurred on the date stated above, at m , The CAUSE OF DEATH* was as follows: still born infant 1 month (Duration) yrs. mos. ds. Contributory Fall from Roller Coaster Secondary at Sparrows Point July 4th (Duration) yrs. mos. ds. (Signed) G. F. McCormick , M. D. July 8th, 1914 (Address) Sparrows Point | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, It not at place of death? Former or usual residence | | | |
| 19 PLACE OF BURIAL OR REMOVAL Sent to Johns Hopkins Anatomical | | DATE OF BURIAL 1914 | |
| 20 UNDERTAKER Dept. Balto | | ADDRESS | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 27, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
May 3 1914 to July 27 1914
that I last saw him alive on July 27 1914

and that death occurred on the date stated above, at 7:40 P m,
The CAUSE OF DEATH* was as follows:

Chromis voluntaria *leucostictus*
discus.
7 (Duration) 6 yrs. mos. ds.

Contributory.....
Secondary.....
..... (Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.
(Signed) James G. Huff, M. D.
July 29, 1914 (Address) Portland, Me.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____

Former or usual residence

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL |
|-------------------------------|----------------|
| | |

Baltimore County July 30 1914

20 UNDERTAKER ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

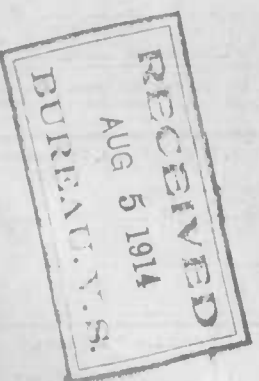
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

8551

County BaltimoreVillage or City St. Agnes Hospital (No. 104)

St. _____ Ward _____

Registration Dist. No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Linder

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH Aug 31, 1913
(Month) (Day) (Year)7 AGE 10 yrs. 10 mos. 27 ds.
If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

PARENTS

10 NAME OF FATHER Christopher Linder11 BIRTHPLACE OF FATHER (State or country) Baltimore12 MAIDEN NAME OF MOTHER Anna Linder13 BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Chris Linder(Address) # 27 Furrow St

15

Filed July 27, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 27, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY That I attended deceased from July 18, 1914 to July 27, 1914that I last saw him alive on July 27, 1914and that death occurred on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows:

Dysentery and enteritis(Duration) _____ yrs. _____ mos. 21 ds.Contributory
Secondary Malnutrition(Duration) _____ yrs. _____ mos. ? ds.(Signed) Robert C. Catech, M. D.July 28, 1914 (Address) St Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. 7 ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence 427 Furrow St19 PLACE OF BURIAL OR REMOVAL Calverton AveDATE OF BURIAL July 29, 191420 UNDERTAKER W. A. SmithADDRESS Balto

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

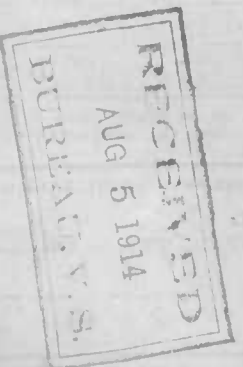
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | | |
|---|---|---|--|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 6552 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Sparks Point</u> | | (No. <u>169</u>) | | Registration Dist. No. <u>44</u> | |
| 2 FULL NAME <u>Saleby Lindsay</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | | | |
| 8 DATE OF BIRTH <u>Sept 25, 1902</u> (Month) (Day) (Year) | | 16 DATE OF DEATH <u>July 8, 1914</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>11</u> yrs. <u>8</u> mos. <u>13</u> ds. OR <u>11</u> yrs. <u>8</u> mos. <u>13</u> ds. | 17 I HEREBY CERTIFY, That I attended deceased from <u>involuntary</u> the death of <u>Saleby Lindsay</u> that I last saw him <u>about 2-P.</u> alive on <u>July 2, 1914</u> and that death occurred on the date stated above, at <u>2-P.</u> m. The CAUSE OF DEATH* was as follows: <u>Accidental drowning while in bathing</u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. | | | | |
| 6 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u> | | Contributory Secondary (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. | | | |
| 9 BIRTHPLACE (State or country) <u>N. C.</u> | | (Signed) <u>Quar N. Roy, Coroner, M.D.</u> <u>791</u> , 191 <u>4</u> (Address) <u>Sparks Point</u> | | | |
| 10 NAME OF FATHER <u>Henry Lindsay</u> | | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>N. C.</u> | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u> </u> | | | |
| 12 MAIDEN NAME OF MOTHER <u>Mamie Allen</u> | | 19 PLACE OF BURIAL OR REMOVAL <u>Asbury Cemetery</u> DATE OF BURIAL <u>July 10th, 1914</u> | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>N. C.</u> | | 20 UNDERTAKER <u>Martin Chase</u> ADDRESS <u>Balto.</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Henry Lindsay</u> (Address) <u>Sparks Point</u> | | | | | |
| 15 Filed <u>July 9th, 1914</u> <u>G. W. Corwin, M.D.</u> REGISTRAR | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 6 1914

McCORMICK, M.D.

SPARROWS POINT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH **6553**
County Baltimore Md

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 36

Village or City Hereford (No. _____, St. _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Gordon Peyton Llewellyn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED XX
(Write the word)

6 DATE OF BIRTH 7 8, 1914
(Month) (Day) (Year)

7 AGE Still Birth If LESS than 1 day.....hrs. yrs. 7 mos. _____ ds. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer) Y

9 BIRTHPLACE (State or country) Hereford Ind

10 NAME OF FATHER Gordon Peyton Llewellyn

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Olivia Ann Parry

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peyton Llewellyn
(Address) Corkeyville Ind

15 Filed July 7, 1914 E. H. Pyle M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 8, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. R. Shuman, M. D.

July 8, 1914. (Address) Sparks Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hereford, Ind. July 7, 1914

20 UNDERTAKER ADDRESS

William P. Llewellyn Corkeyville Ind.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

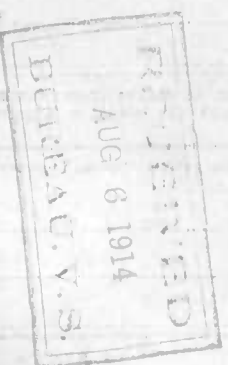
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **6554**
 County **Balto**
 Village or City **Canton** (No. **O'Connell's 22nd**) St. Ward
 Registration Dist. No. **41**
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME **Leonard E. Loeblein**

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Male** 4 COLOR OR RACE **White** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) **Single**
 6 DATE OF BIRTH **March 19, 1911**
 (Month) (Day) (Year)
 7 AGE **3** yrs. **3** mos. **16** ds. **1** LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **July 5, 1914**
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **July 4, 1914** to **July 5, 1914**
 that I last saw him alive on **July 5, 1914**

and that death occurred on the date stated above, at **4:30 P.M.**
 The CAUSE OF DEATH* was as follows:

Contributory
 Secondary

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,
 If not at place of death?

Former or
 usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacred Heart Cem **July 6, 1914**

20 UNDERTAKER

ADDRESS

Lilly Ziller **403 S. Weysser**

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

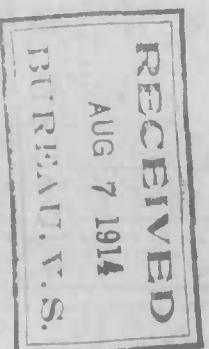
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

6555

County

Baltimore

Village or City

Highlandtown

(No.)

730 S. Chilton

St.;

Ward)

Registration Dist. No.

41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

George Loeffler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

June 17, 1894

(Month)

(Day)

(Year)

7 AGE

19

yrs.

mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore Md.

PARENTS

10 NAME OF FATHER

Joseph Loeffler

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Kunigunda Foertsch

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Loeffler

(Address)

730 S. Chilton St

15

Filed

July 11, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 8th

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, that I attended deceased from July 5, 1914, to July 8, 1914,

that I last saw him alive on July 8, 1914,

and that death occurred on the date stated above, at 10.05 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

6 wks

(Duration)

yrs.

mos.

ds.

Contributory Secondary

Peritonitis

(Duration)

yrs.

mos.

ds.

(Signed)

Charles Drey

July 10, 1914

(Address)

HOS. SACRED HEART AM

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacred Heart Am.

July 11, 1914

20 UNDERTAKER

ADDRESS

Lily E. Jailer

403 S. Wolfe St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 7 1914

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | | |
|---|--|--|--|---|--|
| 1 PLACE OF DEATH | | 6556 | | STATE OF MARYLAND | |
| County | | Baltimore | | CERTIFICATE OF DEATH | |
| Village or City | | (No.) | | Registration Dist. No. | |
| 2 FULL NAME | | Raymond Lutz | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | | | |
| Male | White | Single | | | |
| 6 DATE OF BIRTH | Unknown | | | | |
| 7 AGE | | If LESS than 1 day, . . . hrs. OR . . . min. ? | | | |
| 6 yrs. 6 mos. ds. | | | | | |
| 8 OCCUPATION | | Infant | | | |
| (a) Trade, profession, or particular kind of work | | | | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) | | Baltimore | | | |
| PARENTS | 10 NAME OF FATHER | Raymond Lutz | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) | Unknown | | | |
| | 12 MAIDEN NAME OF MOTHER | Unknown | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) | Unknown | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | |
| (Informant) | | | | | |
| (Address) | | | | | |
| 15 | | | | | |
| Filed, 191 | | | | | |
| REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH | | | | | |
| July 17th, 1914 | | | | | |
| (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from, 191 to, 191 | | | | | |
| that I last saw him alive on, 191 | | | | | |
| and that death occurred on the date stated above, at m. | | | | | |
| The CAUSE OF DEATH* was as follows: | | | | | |
| Gastric Indigestion | | | | | |
| (Duration) yrs. 4 mos. ds. | | | | | |
| Contributory | | | | | |
| Secondary | | | | | |
| (Duration) yrs. mos. ds. | | | | | |
| (Signed) | | | | | |
| July 17, 1914 (Address) | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | |
| At place of death yrs. mos. 3 ds. State yrs. mos. ds. | | | | | |
| Where was disease contracted, If not at place of death? | | | | | |
| Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL | | | | | |
| Unknown | | | | | |
| DATE OF BURIAL, 191 | | | | | |
| 20 UNDERTAKER | | | | | |
| Unknown | | | | | |
| ADDRESS | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

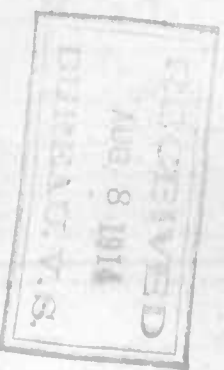
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6557

County

Baltimore, Md.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

42.

Village or City

St. Agnes' Hospital

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William C. Lutz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Oct. 16, 1885

(Month)

(Day)

(Year)

7 AGE

64 yrs. 9 mos. 5 ds.

It LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Pennsylvania

PARENTS

10 NAME OF FATHER

John L. Lutz

11 BIRTHPLACE OF FATHER
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Fannie Eversall

13 BIRTHPLACE OF MOTHER
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David Lutz (son)

(Address)

Chambersburg, Pa.

15

Filed

July 21, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 21, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 9, 1914, to July 21, 1914

that I last saw him alive on July 21, 1914

and that death occurred on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach
Obstruction

(Duration)

yrs.

mos.

ds.

Contributory
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Geo. A. Shinnick

, M. D.

July 21, 1914

(Address)

St. Agnes' Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

in the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

Chambersburg, Pa.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Waynesboro, Md.

July 23, 1914

20 UNDERTAKER

ADDRESS

Chas. L. Brown & Co.

118 W. 2nd St., Pa.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 6558

County BaltimoreVillage or City St. Agnes Hospital (No. 45)

St. Ward

Registration Dist. No. 402

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Myrtle McCall

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 5, 1895
(Month) (Day) (Year)

7 AGE 19 yrs. 1 mos. 28 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Book keeper

9 BIRTHPLACE (State or country)

Alabama

PARENTS

10 NAME OF FATHER

George McCall

11 BIRTHPLACE OF FATHER (State or country)

Alabama

12 MAIDEN NAME OF MOTHER

Bessie Reese

13 BIRTHPLACE OF MOTHER (State or country)

Alabama

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mary W. Welford

(Address)

Fortress Monroe Va.

15

Filed

July 3, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 3, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1914 to July 3, 1914

that I last saw her alive on July 3, 1914

and that death occurred on the date stated above, at 3:45 m.

The CAUSE OF DEATH* was as follows:

Metastatic carcinoma myeloid
thick

(Duration) yrs. mos. ds.

Contributory
SecondaryOf pneumonia shock

(Duration) yrs. mos. ds.

(Signed)

Geo. D. Welford

M. D.

July 3, 1914 (Address) Shannon Bar

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 16 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or

usual residence Fortress Monroe Va.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fortress MonroeJuly 5, 1914

20 UNDERTAKER

ADDRESS

E. M. Welford1201 Fayette

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | |
|---|---------------------------------|--|--|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 6559 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Catonville</u> (No. <u>Spring Eures</u>) | | Registration Dist. No. <u>30</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>Jarrah M. Leace</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Fe</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u> | | | |
| 6 DATE OF BIRTH <u>unk tent, 1830</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>84</u> yrs. <u>unk</u> mos. <u>unk</u> ds. | | | | If LESS than 1 day, ... hrs. OR ... mo. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Canada</u> | | | | | |
| PARENTS | | | | | |
| 10 NAME OF FATHER <u>Andrew M. P. Call</u> | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Scotland</u> | | | | | |
| 12 MAIDEN NAME OF MOTHER <u>unk</u> | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>unk.</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. Jennie Ryan</u> (Address) <u>Balto. Md.</u> | | | | | |
| 15 Filed <u>July 23, 1914</u> <u>Marshall Blunt</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>July 22nd</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>July 17th</u> , 191 <u>4</u> to <u>July 22nd</u> , 191 <u>4</u> that I last saw him alive on <u>July 22nd</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>4:30 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Arterio-sclerosis</u> <u>valvular disease of heart</u> (Duration) yrs. <u>4</u> mos. ... ds. Contributory (Secondary) <u>Senile Dementia</u> (Duration) yrs. <u>2</u> mos. ... ds. (Signed) <u>Percy Wade</u> , M. D. <u>July 23, 1914</u> (Address) <u>Catonville Md.</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>2</u> yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds. Where was disease contracted, If not at place of death? <u>Balto. Md.</u> Former or usual residence <u>Balto. Md.</u> | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL <u>St. Mary's Church</u> <u>July 23, 1914</u> | | | | | |
| 20 UNDERTAKER ADDRESS <u>A. S. Mansell</u> <u>3539 Fall Rd.</u> | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person. Irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be sketched under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 6 1914

BUREAU U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Balto

6560

(48)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 402

Village or City Halethorp (No. _____)

St; _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Emily Mc Crane

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)
6 DATE OF BIRTH May 23, 1844
(Month) (Day) (Year)
7 AGE 70 yrs. 3 mos. 16 ds. If LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Balto Co. Md.

10 NAME OF FATHER John Mc Crane

11 BIRTHPLACE OF FATHER (State or country) Scotland

12 MAIDEN NAME OF MOTHER Sarah Fox

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lillian McCrone
(Address) Halethorp - Md.

15 Filed July 10, 1914 V. S. Ruff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 9th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1914, to July 9th, 1914, that I last saw him alive on July 8th, 1914, and that death occurred on the date stated above, at 3.20 P. m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis
(Duration) 7 yrs. _____ mos. _____ ds.
Contributory (Secondary) Serum
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. H. V. Roush, M. D.
July 9th, 1914 (Address) Halethorp - Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, if not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Greenmount Cemetery DATE OF BURIAL July 11, 1914
20 UNDERTAKER Geo. P. Roush ADDRESS Sanville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

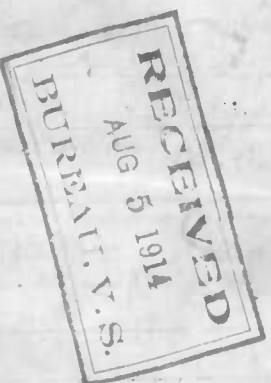
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma. Sarcoma, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6561

County BaltimoreVillage or City Arlington (No. 101 Virginia Ave St. 3 Ward)2 FULL NAME Paroline J. P. McElbournSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 22

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow
(Write the word)6 DATE OF BIRTH March, 1834
(Month) (Day) (Year)7 AGE 80 yrs. 4 mos. 4 ds. If LESS than 1 day, hrs. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work house.
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) England10 NAME OF FATHER James Nelson11 BIRTHPLACE OF FATHER (State or country) Scotland12 M maiden NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (State or country) " "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Mamiel C. McElbourn(Address) 101 Virginia Ave15 Filed July 18, 1914 Geo. F. Queen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 14, 1914, to July 17, 1914, that I last saw her alive on July 17, 1914and that death occurred on the date stated above, at 5:30 a.m.
The CAUSE OF DEATH* was as follows:Chronic Nephritis(Duration) 7 yrs. 6 mos. 4 ds.
Contributory (Secondary) General Arterio Sclerosis(Duration) 10 yrs. 10 mos. 4 ds.
(Signed) James S. Arment, M. D.
July 18, 1914. (Address) 4012 Paul Heights

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 7 yrs. 6 mos. 4 ds. In the State 7 yrs. 6 mos. 4 ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Smith Ridge DATE OF BURIAL July 19, 191420 UNDERTAKER Low Cook ADDRESS 2016 North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

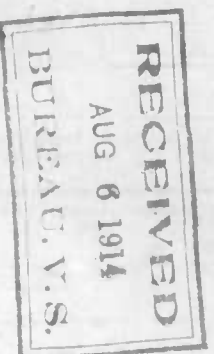
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

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1 PLACE OF DEATH

6562

County

Baltimore

Village or City

Parkton

(No.

St.;

Ward)

Registered No. 26

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charlie Jasper Martin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

11 18 18 34
(Month) (Day) (Year)

7 AGE

79 yrs. 7 mos. 17 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Harford Co Md

PARENTS

10 NAME OF FATHER

John Martin

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Prudence Magni

13 BIRTHPLACE OF MOTHER (State or country)

Harford Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rachel Martin

(Address)

Parkton No 3

15

Filed

July 5, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

7 5, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June, 1914, to July, 1914.

that I last saw him alive on July 11, 1914

and that death occurred on the date stated above, at 1-20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of larynx
(Duration) 3 yrs. 1 mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) B. M. Shumanture, M. D.

July 5, 1914. (Address) Sparks Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hereford Baptist Church July 7, 1914

20 UNDERTAKER

ADDRESS

Wm C Brooks Sparks

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

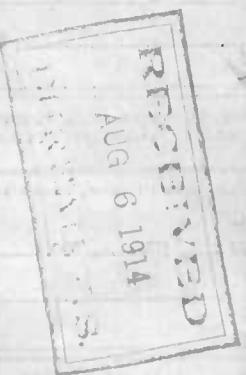
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Oma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6563

County

Baltimore Co

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Calgary

(No.)

Brook Hill

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Agnes Matuzewski

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

June 18, 1914

7 AGE

19 yrs. 19 mos. 19 ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Balto. Co.

PARENTS

10 NAME OF FATHER

Stanislaus Matuzewski

11 BIRTHPLACE OF FATHER (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Mastyza Pijot

13 BIRTHPLACE OF MOTHER (State or country)

Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Stanislaus Matuzewski

(Address)

Brook Hill

15

Filed

July 6, 1914 W. E. McCaughey

Registered

16 DATE OF DEATH

July 6, 1914

17

I HEREBY CERTIFY, That I attended deceased from

1914 to 1914

that I last saw him alive on 1914

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal Infection

(Duration) yrs. mos. 3 ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed)

E. Williams

M. D.

(Address) Calgary, Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cem. July 7, 1914

20 UNDERTAKER

ADDRESS

Stephen Fialkowski 1027 S.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Kenwood

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

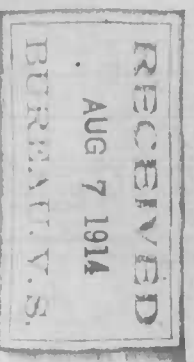
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | | | | | | | |
|--|--|---------------------------------|-------------|---|--|--|--|--|---|--|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | | 5564 | | | 172 | | | STATE OF MARYLAND CERTIFICATE OF DEATH | | |
| Village or City <u>Parkton</u> | | | (No. _____) | | | St.; _____ Ward _____ | | | Registration Dist. No. <u>36</u> | | |
| 2 FULL NAME <u>Nicholas F. Mayes</u> | | | | | | | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | MEDICAL CERTIFICATE OF DEATH | | | | | |
| 3 SEX <u>Male</u> | | 4 COLOR OR RACE <u>White</u> | | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>married</u> | | 16 DATE OF DEATH <u>July 7, 1914</u> (Month) (Day) (Year) | | | | | |
| 6 DATE OF BIRTH <u>November 13, 1887</u> (Month) (Day) (Year) | | | | | | 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____. | | | | | |
| 7 AGE <u>26</u> yrs. <u>7</u> mos. <u>24</u> ds. | | | | | | that I last saw him _____ alive on _____, 191____. | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | | and that death occurred on the date stated above, at about <u>2</u> p. m. The CAUSE OF DEATH* was as follows: <u>Accidentally falling from back floor to earth below a distance of 10 or 12 feet, resulting in broken neck.</u> | | | | | |
| 9 BIRTHPLACE (State or country) <u>Baltimore, Md.</u> | | | | | | Contributory (Secondary) _____ | | | | | |
| 10 NAME OF FATHER <u>John C. Mayes</u> | | | | | | (Duration) _____ yrs. _____ mos. _____ ds. | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> | | | | | | (Signed) <u>A. R. Mitchell</u> , M. D. | | | | | |
| 12 MAIDEN NAME OF MOTHER <u>Harriett Foster</u> | | | | | | <u>July 17, 1914</u> (Address) <u>Parkton, Md.</u> | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> | | | | | | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Margaret Mayes</u> (Address) <u>Parkton, Md.</u> | | | | | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. | | | | | |
| 15 Filed <u>July 10, 1914</u> | | | | | | Where was disease contracted, it not at place of death? Former or usual residence _____ | | | | | |
| 16 REGISTRAR <u>E. Le Roy Stipple</u> | | | | | | 19 PLACE OF BURIAL OR REMOVAL <u>Hereford M. E.</u> | | | | | |
| | | | | | | 20 UNDERTAKER <u>E. Le Roy Stipple</u> | | | | | |
| | | | | | | DATE OF BURIAL <u>July 10, 1914</u> | | | | | |
| | | | | | | ADDRESS <u>Parkton</u> | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaster, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—(coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

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1 PLACE OF DEATH

6565

County BaltimoreVillage or City Canton (No. 3421, First Ave St.; 41 Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Elizabeth Maygers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)Widowed

6 DATE OF BIRTH

Not known
(Month) (Day) (Year)

7 AGE

81 yrs. mos. ds. 1 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Ind

PARENTS

10 NAME OF FATHER

John Parlett11 BIRTHPLACE OF FATHER
(State or country)Ind

12 MAIDEN NAME OF MOTHER

Not known13 BIRTHPLACE OF MOTHER
(State or country)Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bern Maygers

(Address)

3421 First Ave

15

Filed July 12, 1914W. C. McClanahan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 10, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 25, 1914, to July 10, 1914,
that I last saw her alive on July 9, 1914.and that death occurred on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

David W. Jones, M. D.
July 10, 1914 (Address) 3116 Edmond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount Carmel Cem. July 12, 1914

20 UNDERTAKER

ADDRESS

H. Lander Sons 1710 Fleet St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

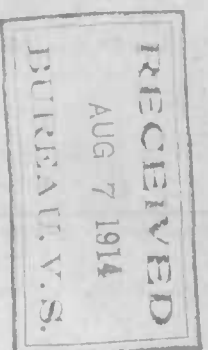
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

County

Baltimore

6566

(8)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

32

Village or City

Wilmington (No. 212 Belvidere Ave.)

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Walter King Meyers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED(Write the word)
Single

6 DATE OF BIRTH

May 19, 1914
(Month) (Day) (Year)

7 AGE

yrs. 2 mos. - ds.

1 LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9 BIRTHPLACE

(State or country)

Baltimore Md

PARENTS

10 NAME OF FATHER

J. Herman Meyers

11 BIRTHPLACE OF FATHER

(State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Catherine King

13 BIRTHPLACE OF MOTHER

(State or country)

Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Herman Meyers

(Address)

212 Belvidere Ave

15

Filed

July 20, 1914 Henry G. Naylor

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 19, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

July 17, 1914, to July 19, 1914,
that I last saw him alive on July 18, 1914

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) yrs. mos. 10 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Leonard E. Beach, M. D.

July 19, 1914 (Address) 837 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross Cemetery, July 21, 1914

20 UNDERTAKER

ADDRESS

Geo. A. Gerbig Baltimore

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

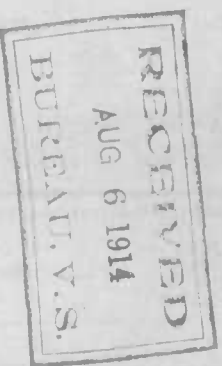
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PREPERAL septicæmia," "PERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6567

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 30Village or City Windsor Hills (No. Bungalow Apts) St; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Margaret Estelle Milbourne

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 27, 1882
(Month) (Day) (Year)

7 AGE 32 yrs. 0 mos. 4 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Baltimore

PARENTS
10 NAME OF FATHER L. Jeff. Milbourne
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Maggie E. McGee
13 BIRTHPLACE OF MOTHER (State or country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. L. Jeff. Milbourne
(Address) Windsor Hills

15 Filed July 31, 1914 A. C. Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July - 31, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from _____, 1914, to July 31, 1914, that I last saw her alive on July 31, 1914,

and that death occurred on the date stated above, at 2:45 P. M.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs
Tuberculosis
(Duration) 3 yrs. _____ mos. _____ ds.

Contributory General debility
(Secondary) (Duration) _____ yrs. 6 mos. _____ ds.

(Signed) Dr. W. C. Ellis, M. D.
July 31, 1914 (Address) 2202 Garrison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Louisa Park Chy DATE OF BURIAL Aug 3, 1914

20 UNDERTAKER Steward Mowen Company ADDRESS 15 W. Eager St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

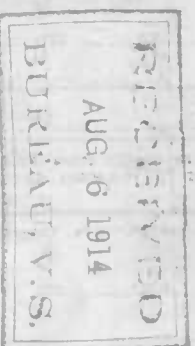
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality, as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



HEALTH DEPARTMENT—CITY OF BALTIMORE

6568

CERTIFICATE OF DEATH

Registration No. 38.
REGISTERED NO. C

1-PLACE OF DEATH

County
CITY OF BALTIMORE: (No. *Charles St & Lake Avenue* ST.;..... WARD)

2-FULL NAME

Eliza J. Miller
(Residence in Baltimore Co. No. *Charles St & Lake Avenue* St.;..... yrs.,..... mos..... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow*
(Write the word.)

6-DATE OF BIRTH,

July 25, 1831.
(Month) (Day) (Year)

7-AGE,

83 yrs..... mos..... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
- At Home*
-
- (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),*Baltimore City*

PARENTS.

10-NAME OF FATHER,

*Samuel Beran*11-BIRTHPLACE OF FATHER
(State or Country),*Baltimore*

12-MAIDEN NAME OF MOTHER

*May Harvey*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *Eugene G. Miller Jr.*(Address)..... *Charles St & Lake Ave - Balto...*

15-

Filed..... 191..... *M. J. Porter* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

July 26, 1914.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 17* 1914, to *July 25* 1914, that I saw h *er* alive on *July 25* 1914, and that death occurred, on the date stated above, at *12-45* m.

The CAUSE OF DEATH* was as follows:

At Home
Cerebral Hemorrhage
(Duration)..... yrs..... mos. *14* ds.CONTRIBUTORY
(Secondary)(Signed)..... *No. 17 St. John's* M. D.
7/26, 1914. (Address)..... *Corona, Balto Co.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Sorraine Cemetery

DATE OF BURIAL,

July 28, 1914.

20-UNDERTAKER

H W Jenkins & Co

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the disease causing DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

lungs, meninges, peritoneum, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

| | | | |
|-------------|--------------|-------------|--------------|
| Abortion, | Cottitis, | Childbirth, | Convulsions, |
| Hæmorrhage, | Gastritis, | Erysipelas, | Meningitis, |
| Gangrene, | Miscarriage, | Necrosis, | Peritonitis, |
| Phlebitis, | Pneumonia, | Septicæmia, | Tetanus. |

The following must be referred to a Coroner: Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

6569

County

Baltimore, Md.

42

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

42.

Village or City

St. Agnes' Hospital

St.

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mrs. Nettie Montgomery

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widow

6 DATE OF BIRTH

October, 30, 1872

7 AGE

42 yrs. 9 mos. 9 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Mr. E. J. Bishop

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Coakley

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Sadie Bishop

(Address)

1008 N. E. Culloch St.

15

Filed

July 21, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 21, 1914

17 I HEREBY CERTIFY, That I attended deceased from

April 27, 1914, to July 21, 1914, that I last saw her alive on July 21, 1914, and that death occurred on the date stated above, at 12:11 am.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri
General MetastasisContributory
Secondary

(Signed)

G. W. Stewart, M. D.
July 21, 1914 (Address) St. Agnes' Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 3 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

Smithsburg, Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Smithsburg, Md. July 22, 1914

20 UNDERTAKER

ADDRESS

Stewart & Marwala 15 W. Eager

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

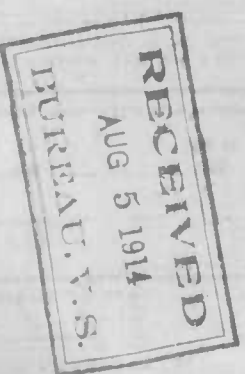
[Approved by U. S. Census and American Public Health Association.]

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 6570
County Balto
Village or City Colgate (No. Bear Creek St.; Ward)
2 FULL NAME Ed. A. Morningstar
Registration Dist. No. 41
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male **4 COLOR OR RACE** W **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** married
 (Write the word)

6 DATE OF BIRTH unknown
 (Month) (Day) (Year)

7 AGE 25 — —
 yrs. mos. ds. **8 OCCUPATION** Barber
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE MD
 (State or country)

PARENTS

10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER unknown
 (State or country)
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER unknown
 (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Chas. A. Jackson
 (Address) 701 W. Fayette

15 July 5, 1914 W. E. McLaughlin
 Filed July 5, 1914 W. E. McLaughlin
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 5, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
191 to 1914
 that I last saw him live on 191
 and that death occurred on the date stated above, at m,
 The CAUSE OF DEATH* was as follows:
accidental poisoning
 (Duration) — yrs. — mos. — ds.

Contributory
 Secondary
 (Duration) — yrs. — mos. — ds.

(Signed) A. M. Mewer M. D.
7-5, 1914 (Address) Crover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.
 Where was disease contracted, if not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL 2334 Jefferson St. **DATE OF BURIAL** July 5/14, 1914
20 UNDERTAKER Christian Miller **ADDRESS** 2334 Jefferson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Spock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal," *septicæmia*, "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6571

County

Baltimore

Village or City

Hullville

(No.

St.;

Ward)

Registration Dist. No.

42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Leah Susan Munroe

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Cauc

5 SINGLE,

MARRIED,

WIDOWED,

OR SEPARATED

(Write the word)

Married

6 DATE OF BIRTH

9

30

1862

(Month)

(Day)

(Year)

7 AGE

5-2

yrs.

2

mos.

28

ds.

or LESS than

1 day, hrs.

or min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Virginia

PARENTS

10 NAME OF FATHER

Thomas Drummond

11 BIRTHPLACE OF FATHER (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Mary Dip

13 BIRTHPLACE OF MOTHER (State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Munroe

(Address)

Mt. Winans, Md.

15

Filed

July 5, 1914

4

F. H. Ruhl

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 2

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec 19-

1913

to

June 30

1914

that I last saw her alive on

June 30

1914

and that death occurred on the date stated above, at 5:15 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration)

yrs.

7

mos.

ds.

Contributory
Secondary

Exhaustion

(Duration)

yrs.

mos.

ds.

(Signed)

W. B. Hall

, M. D.

(Address)

Mt. Winans

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cemetery

July 5, 1914

20 UNDERTAKER

ADDRESS

Geo. H. Hooper

609 Sixth St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicaemia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Village or City

(No.

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

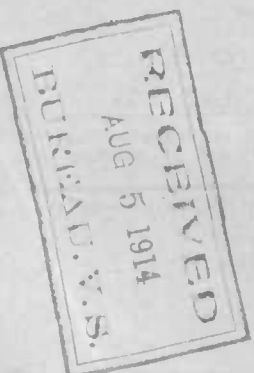
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1 PLACE OF DEATH **6573**
County Baltimore

Village or City Gorantown (No. 5 Glenwood Ave) St.; Ward

2 FULL NAME Clara Nicholas

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX De 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH 12 1 1898
(Month) (Day) (Year)

7 AGE 15 yrs. 7 mos. 21 ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work School-girl
(b) General nature of industry, business, or establishment in which employed (or employer) School-girl

9 BIRTHPLACE (State or country) Gorantown, Md

10 NAME OF FATHER Thomas Curtis

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Nicholas

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Nicholas
(Address) 59 Glenwood Ave

15 Filed 7/22, 1914 Clara J. Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 21 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1914 to July 21, 1914, that I last saw her alive on July 21, 1914.

and that death occurred on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:

Acute Phthisis

(Duration) 3 yrs. 3 mos. 3 ds.

Contributory (Secondary)

(Signed) P. Garland Whizell, M. D.
(Duration) July 21, 1914. (Address) 424 - East 23 St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Graveyard Gorantown DATE OF BURIAL July 23, 1914

20 UNDERTAKER Samuel T. Thomas ADDRESS 578 N. Bedle

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

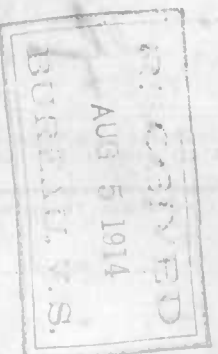
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH **6574**
County *Baltimore*

Village or City *Sparrows Point* (No. *22*, West E. St.; Ward)

2 FULL NAME *Annie Nitzke*

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. *444*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *W* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *single*
(Write the word)

DATE OF BIRTH *June 26*, 191*2*
(Month) (Day) (Year)

7 AGE *2* yrs. *12* mos. *12* ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work *none*
(b) General nature of Industry, business, or establishment in which employed (or employer) *none*

9 BIRTHPLACE (State or country) *Sparrows Point Md*

10 NAME OF FATHER *Frank Nitzke*

11 BIRTHPLACE OF FATHER (State or country) *Austria*

12 MAIDEN NAME OF MOTHER *Josephine Tanselox*

13 BIRTHPLACE OF MOTHER (State or country) *Austria*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Frank Nitzke*

(Address) *Sparrows Point*

15 Filed *July 8*, 191*4* *G. C. McCormick*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 7th*, 191*4*
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from *June 25*, 191*4*, to *July 7th*, 191*4*, that I last saw her alive on *July 7th*, 191*4*.

and that death occurred on the date stated above, at *9 P.* m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Duration) yrs. mos. *10* ds.

Contributory *Whooping Cough*
Secondary

(Signed) *G. C. McCormick*, M. D.
July 8th, 191*4* (Address) *Sparrows Point*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *St Stanislaus* DATE OF BURIAL *July 9th*, 191*4*

20 UNDERTAKER *Frank O'rack* ADDRESS *Balto. City*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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J. C. McCORMICK, M.D.

SPARROWS, PHOT.

RECEIVED
AUG 6 1914

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH County <u>Balto.</u> <u>6575</u> <u>(9)</u> | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Halbthorp</u> (No. <u>Washington Road</u>) Ward | | Registration Dist. No. <u>42</u> | |
| 2 FULL NAME <u>Charles J. Odenros</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | |
| 6 DATE OF BIRTH <u>May 20, 1914</u> (Month) (Day) (Year) | | | |
| 7 AGE yrs. <u>1</u> mos. <u>19</u> ds. | | If LESS than 1 day, hrs. OR min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>child</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) <u>Balto Md</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Jm Odenros</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Balto. Md</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Annie E. Oold</u> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Balto Md</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jm Odenros</u> (Address) <u>park, Rd. Baltco</u> | | | |
| 15 FILED <u>July 10, 1914</u> <u>F. W. Ruhl</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>July 9, 1914</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>July 8, 1914</u> to <u>July 9, 1914</u> that I last saw him alive on <u>July 15, 1914</u> and that death occurred on the date stated above, at <u>11-30 P. M.</u> The CAUSE OF DEATH* was as follows: <u>Whooping Cough</u> (Duration) <u>10</u> yrs. <u>10</u> mos. <u>10</u> ds. | | | |
| Contributory Secondary <u>same</u> (Duration) <u>7</u> yrs. <u>7</u> mos. <u>7</u> ds. | | | |
| (Signed) <u>Geo L. McKeeffer</u> , M. D. <u>July 10, 1914</u> (Address) <u>Monell Park Md</u> | | | |
| State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>7</u> yrs. <u>7</u> mos. <u>7</u> ds. In the State <u>7</u> yrs. <u>7</u> mos. <u>7</u> ds. Where was disease contracted, If not at place of death? Former or usual residence. | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Family Burial Lot</u> | | DATE OF BURIAL <u>July 11, 1914</u> | |
| 20 UNDERTAKER <u>Book</u> | | ADDRESS <u>302 E. Choke</u> | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

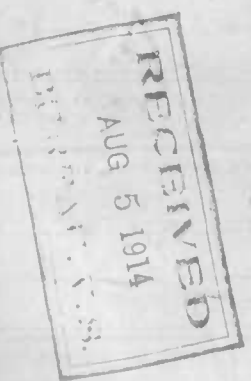
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6576
 County Baltimore
 Village or City Mt Home Retreat No. 68

STATE OF MARYLAND CERTIFICATE OF DEATH

 Registration Dist. No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rev Edward H. O'Donnell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)
 6 DATE OF BIRTH Not Known
 (Month) (Day) (Year)
 7 AGE abt 41 yrs. 0 mos. 0 ds. It LESS than 1 day. hrs. OR min. ?
 8 OCCUPATION (a) Trade, profession, or particular kind of work Clergyman
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ireland
 10 NAME OF FATHER Ignatius O'Donnell
 11 BIRTHPLACE OF FATHER (State or country) Ireland
 12 MAIDEN NAME OF MOTHER Mary Coghlan
 13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Records of Mt Home Retreat
 (Address) Mt Home Md.

15 Filed July 17, 1914 Wm J Queen
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 6th, 1914, to July 17th, 1914
 that I last saw h. live alive on July 16th, 1914

and that death occurred on the date stated above, at 8.30 A.m.

The CAUSE OF DEATH* was as follows:

Mania Chronica

Contributory Acute Gastritis
 Secondary abt (Duration) 3 yrs. 7 mos. 0 ds.

(Signed) Frank J. Cairney, M. D.
July 17th, 1914 (Address) Mt Home Retreat

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 2 yrs. 0 mos. 0 ds. In the State 2 yrs. 0 mos. 0 ds.

Where was disease contracted, Penna
 If not at place of death?

Former or usual residence Phila. Pa.

19 PLACE OF BURIAL OR REMOVAL Phila. Penna DATE OF BURIAL July 17, 1914

20 UNDERTAKER Stewart Hovew Co ADDRESS 15 W Eager St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

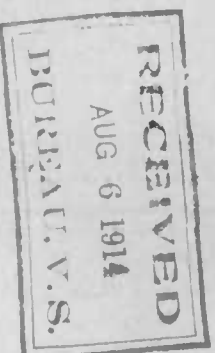
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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, STUPIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | |
|---|---|---|---|
| 1 PLACE OF DEATH County <u>Baltimore</u> <u>6577</u> | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>St Denis</u> (No. <u>104</u>) | | Registered No. <u>42</u> | |
| 2 FULL NAME <u>Francis Marie O'Malley</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | MEDICAL CERTIFICATE OF DEATH | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | 16 DATE OF DEATH <u>July 22</u> , 191 <u>4</u> (Month) (Day) (Year) |
| 6 DATE OF BIRTH <u>Oct 24</u> , 191 <u>4</u> (Month) (Day) (Year) | | 17 I HEREBY CERTIFY, That I attended deceased from <u>July 5th</u> , 191 <u>4</u> , to <u>July 22</u> , 191 <u>4</u> , that I last saw her alive on <u>July 21st</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>2³⁰</u> A. M. The CAUSE OF DEATH* was as follows: <u>Dec Coctis</u> | |
| 7 AGE <u>8</u> yrs. <u>27</u> mos. <u>8</u> days | If LESS than 1 day, hrs. OR min. ? | | Contributory (Secondary) <u>Exhaustion (Chesh)</u> |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) | | | (Duration) yrs. mos. <u>27</u> ds. |
| 9 BIRTHPLACE (State or country) <u>Ind</u> | | | (Duration) yrs. mos. <u>1</u> ds. |
| 10 NAME OF FATHER <u>Vincent B O'Malley</u> | | (Signed) <u>Wm R. Eganckan</u> , M. D. | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u> | | <u>July 22</u> , 191 <u>4</u> (Address) <u>Oak Ridge</u> | |
| 12 MAIDEN NAME OF MOTHER <u>Mable Forgan</u> | | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Scotland</u> | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Vincent B O'Malley</u> (Address) <u>St Denis</u> | | 19 PLACE OF BURIAL OR REMOVAL <u>Elthidge MA</u> | |
| 15 Filed <u>July 22</u> , 191 <u>4</u> <u>T. R. Ruhl</u> REGISTRAR | | DATE OF BURIAL <u>July 27th</u> , 191 <u>4</u> | |
| | | 20 UNDERTAKER <u>Lied fill</u> ADDRESS <u>Elthidge MA</u> | |

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

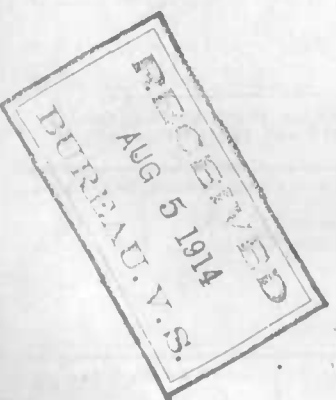
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1 PLACE OF DEATH • 6578
County Balto.

Village or City Fork (No. _____, St.; _____ Ward)

2 FULL NAME

Elizabeth M. Crew

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 40

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Oct. 10, 1829
(Month) (Day) (Year)

7 AGE 84 yrs. 9 mos. 0 ds. If LESS than 1 day, ... hrs. OR ... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Penna

10 NAME OF FATHER Isaac Van Horn

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER Elizabeth Chamberlin

13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Aussie Schults

(Address) Upper Falls Ind

15 Filed July 12, 1914 J. F. H. Gorseman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 10, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1914, to July 10, 1914, that I last saw h. s. alive on July 10, 1914.

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy Brain
In cerebral artery
(Duration) ... yrs. ... mos. 6 ds.

Contributory (Secondary) same

(Duration) ... yrs. ... mos. 6 ds.

(Signed) J. F. H. Gorseman, M. D.
July 11, 1914 (Address) Fork Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, it not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Franklinville Cemetery DATE OF BURIAL July 13, 1914

20 UNDERTAKER Johnathan Brown ADDRESS Fork

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

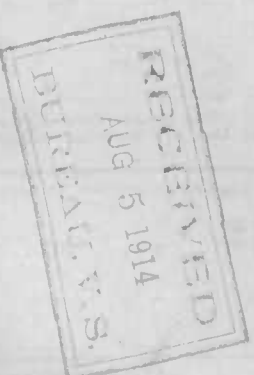
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—(coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Prosy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH, 6579 | | STATE OF MARYLAND | |
| County <u>Baltimore</u> | | CERTIFICATE OF DEATH | |
| Village or City _____ (No. _____, St. _____, Ward _____) | | Registration Dist. No. <u>31</u> | |
| 2 FULL NAME <u>Emory Pardee</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>S</u> | |
| 6 DATE OF BIRTH <u>Oct. 18, 1912</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>8</u> <u>1</u> yrs. <u>20</u> mos. <u>0</u> ds. | | If LESS than 1 day, _____ hrs. OR _____ min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | | |
| 9 BIRTHPLACE (State or country) <u>Baltimore, Md.</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Charles Pardee</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. M. K. Jr.</u> (Address) <u>1201 W. Fayette St.</u> | | | |
| 15 _____, 191____ Filed _____ REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>July 4th, 1914</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____ that I last saw him _____, alive on _____, 191____ and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Ilus Colitis</u> (Duration) _____ yrs. <u>2</u> mos. _____ ds. | | | |
| Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. | | | |
| (Signed) <u>J. M. K. Jr.</u> , M. D. <u>July 4, 1914</u> (Address) <u>1201 W. Fayette St.</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. <u>4</u> ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, <u>At Home</u> If not at place of death? <u>Baltimore</u> Former or usual residence _____ | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Druid Ridge</u> | | DATE OF BURIAL <u>July 5, 1914</u> | |
| 20 UNDERTAKER <u>E. M. Mitchell</u> | | ADDRESS <u>1201 W. Fayette St.</u> | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

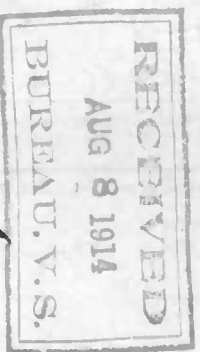
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.—Every item of information should be carefully supplied. AGE should be stated **EXACTLY**. **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms, so that it may be properly classified. Exact statement of **OCCUPATION** is very important. See instructions on back of certificate.

| | |
|---------------|-----------------|
| 20 UNDERTAKER | ADDRESS |
| Wes H Hooker | 609 Little Rock |

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

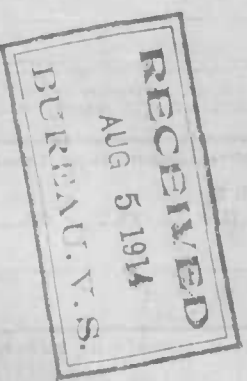
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1 PLACE OF DEATH

6581

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highland (No. 532 S Third St.)

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Un-named (Still-Birth)

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|--------------------------|---|
| 3 SEX unknown | 4 COLOR OR RACE white | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) 4 |
| 6 DATE OF BIRTH July 6, 1914 (Month) (Day) (Year) | | |
| 7 AGE C | | It LESS than 1 day, hrs. yrs. mos. ds. OR min. ? |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) | | |

9 BIRTHPLACE
(State or country)

Balto., Co.

PARENTS

| |
|---|
| 10 NAME OF FATHER Claude Parsons |
| 11 BIRTHPLACE OF FATHER (State or country) Baltimore |
| 12 MAIDEN NAME OF MOTHER Lillian Mitchell |
| 13 BIRTHPLACE OF MOTHER (State or country) Baltimore |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lillian Parsons

(Address)

532 S. Third St.

15

Filed

July 8, 1914

REGISTERED

MEDICAL CERTIFICATE OF DEATH

| |
|--|
| 16 DATE OF DEATH July 6, 1914 (Month) (Day) (Year) |
| 17 I HEREBY CERTIFY, That I attended deceased from, 191....., to 191..... that I last saw h. C. alive on 191..... and that death occurred on the date stated above, at 11 4 m. The CAUSE OF DEATH* was as follows: Embryo-Utero-Involution 2 1/2 months. (Duration) yrs. mos. ds. |

Contributory
Secondary

(Signed) Jos. Hamilton, M. D.
July 7, 1914 (Address) 939 S. Third St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Carmel Cem. July 8, 1914
20 UNDERTAKER
Lily E. Ziehl
ADDRESS
403 S. W. 10th St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Seule," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 7 1914

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH **6582**
County Baltimore

Village or City near Hampster (No. 64)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 034

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Susan Patterson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH October 3rd, 1836
(Month) (Day) (Year)

7 AGE 77 yrs. 8 mos. 28 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Retired Housework
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Baltimore Co.

10 NAME OF FATHER George Bantlitz

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Frank

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E. Han

(Address) 167 Belvedere Ave. Arlington

15 Filed Aug 1, 1914 C. E. Foyth REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 31, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from May, 1914, to July 31, 1914

that I last saw her alive on July 26, 1914

and that death occurred on the date stated above, at her m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) Paralysis

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. A. Prussing, M. D.

____, 191____ (Address) Hampster

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grove Run

Aug 2, 1914

20 UNDERTAKER

ADDRESS

Thos. F. Shearer

Millers Ind.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same important term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Maras- mus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæ- mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For vio- lent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac- cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla- ture of the American Medical Association.)

If this certificate is looked over thoroughly and all ques- tions answered in detail, it will prevent further correspon- dence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 6583

County BaltoVillage or City Highlandtown (No. 503 S. 3rd)2 FULL NAME Mary E. PetersSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[if death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Mar 17th, 1843
(Month) (Day) (Year)

7 AGE

71 yrs. 4 mos. 7 ds. 0 min. ?
If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Balto Co.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm B. Evans

(Address)

503 S. 3rd St.

15

Filed

July 25th, 1914 W. E. McLaughlin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 24, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from June 8, 1914, to July 24, 1914.that I last saw him alive on July 24, 1914.and that death occurred on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Senile pneumonia.

Contributory

Secondary

Cerebral Hemiplegia
(Duration) yrs. mos. ds.

(Signed)

W. E. McLaughlin
July 25th, 1914 (Address) 619 S. Clinton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak LawnJuly 27th, 1914

20 UNDERTAKER

ADDRESS

Philip Herwig 2016 Orleans St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 7 1914

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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6584

STATE OF MARYLAND
CERTIFICATE OF DEATH

County Baltimore Thos. Wilson Sanitarium Registration Dist. No. 31

Village or City W. Wilson, Md. (No. 21) (Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Dorothy Phelps

| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | |
|--|---|---|--|---|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>Black</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>S</u> | 16 DATE OF DEATH <u>July 15th, 1914</u> Month Day Year | 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Congenital Syphilis</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>John Knapp Jr.</u> , M. D. <u>July 15, 1914</u> (Address) <u>W. Wilson</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |
| 6 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year) | 7 AGE <u>2</u> yrs. _____ mos. _____ ds. OR _____ min. ? It LESS than 1 day, _____ hrs. | 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. <u>3</u> ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? <u>at home</u> Former or usual residence <u>Baltimore</u> | |
| 9 BIRTHPLACE (State or country) <u>Baltimore, Md.</u> | | | 19 PLACE OF BURIAL OR REMOVAL <u>Unknown</u> DATE OF BURIAL _____, 191____ | |
| 10 NAME OF FATHER <u>Wm. Phelps</u> | | | 20 UNDERTAKER <u>Unknown</u> ADDRESS _____ | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> | | | | |
| 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Knapp Jr.</u> (Address) <u>W. Wilson, Md.</u> | | | | |
| 15 Filed _____, 191____ REGISTRAR _____ | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

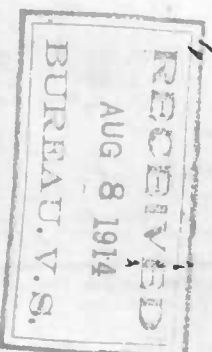
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6585

County

Baltimore
North Point

Village or City

S. S.
Sparrow Point (No. Route 10)

Registration Dist. No.

44

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Still born infant Pigeon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

ORDIVORCED

(Write the word)

Single

6 DATE OF BIRTH

July 26th, 1914
(Month) (Day) (Year)

7 AGE

— yrs. — mos. — ds. ☒ LESS than 1 yr. ☐ 1 yr. or more?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Sparrow Point

10 NAME OF FATHER

Vincent Pigeon

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Kasman

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Vincent Pigeon

(Address)

North Point Md.

15

Filed

July 25, 1914 G. H. McCormick
REGISTRARSTATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 25th, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

—, 191—, to July 25th, 1914.

that I last saw h. — alive on —, 191—

and that death occurred on the date stated above, at 12:59 p.m.

The CAUSE OF DEATH* was as follows:

Still Birth

(Duration) — yrs. — mos. — ds.

Contributory

Secondary

(Duration) — yrs. — mos. — ds.

(Signed) Frank C. Geddes, M. D.
July 25, 1914 (Address) Sparrow Point

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

—, 191—

20 UNDERTAKER

ADDRESS

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 6586

County Balto

(28)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 33Village or City Owings Mills (No. Rosewood Training School St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Claude Poulsen Pollitt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept. 3, 1889
(Month) (Day) (Year)7 AGE 24 yrs. 10 mos. 3 ds. OR 1 day, 1 hrs. 1 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland.

10 NAME OF FATHER Joshua D Pollitt
11 BIRTHPLACE OF FATHER (State or country) Maryland.
12 MAIDEN NAME OF MOTHER Ellen Maddox
13 BIRTHPLACE OF MOTHER (State or country) Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank W. KeatingAddress Owings Mills, Md.15 Filed July 7, 1914 J. J. Mendenhall
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 6, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from June 2, 1914, to July 6, 1914, that I last saw him alive on July 6, 1914and that death occurred on the date stated above, at 11:15 a. m.
The CAUSE OF DEATH* was as follows:Pulmonary tuberculosis(Duration) One yrs. 0 mos. 0 ds.Contributory Secondary(Duration) 0 yrs. 0 mos. 0 ds.(Signed) Kenneth B. Jones, M. D.
July 6, 1914. (Address) Owings Mills, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death 1 yrs. 11 mos. 13 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence Salisbury Md.19 PLACE OF BURIAL OR REMOVAL Salisbury, Md. DATE OF BURIAL July 8, 191420 UNDERTAKER F. E. Chene ADDRESS Reston

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word *farmer* on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fenital" "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæ-mia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

' PLACE OF DEATH 6587
County Baltimore
Village or City Lansdowne (No. 5)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 42

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME JAMES PORTO

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH 7 17, 1914
(Month) (Day) (Year)

7 AGE still born It LESS than 1 day, _____ hrs. OR _____ min. ?
yrs. _____ mos. _____ ds.

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Lansdowne

PARENTS
10 NAME OF FATHER Wm. A. Porto
11 BIRTHPLACE OF FATHER (State or country) Baltimore
12 MAIDEN NAME OF MOTHER Maggie O. Driver
13 BIRTHPLACE OF MOTHER (State or country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. W. A. Porto
(Address) Lansdowne Md.

15 Filed July 18, 1914 F. H. Ruhl
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 17, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 7-17, 1914 to 7-17, 1914.

that I last saw him _____ alive on _____, 1914.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

asphyxiation
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory asphyxiation
Secondary _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) 763 Hale, M. D.
7-18, 1914. (Address) Int. M. M. Co.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, if not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL W. O. Ruhl DATE OF BURIAL July 18, 1914

20 UNDERTAKER W. O. Ruhl ADDRESS Balro. St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Pebility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or NONFATAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6588

County Balto.Village or City Canton (No. 907, S. East Ave. St.: _____ Ward) _____STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jane Rodney

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH June 15, 1899
(Month) (Day) (Year)

7 AGE 55 yrs. 1 mos. 13 ds. OR 1 day, 13 hrs. OR 1 min. ?
It LESS than

8 OCCUPATION
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER David Samuels

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Mary Leyshon

13 BIRTHPLACE OF MOTHER (State or country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edw. H. Rodney(Address) 907 S. East Ave.

15 July 30, 1914 W. H. Clavahan
Filed _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 28, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 21, 1914, to July 28, 1914.

that I last saw him alive on July 27, 1914.

and that death occurred on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis
of Arturo Scherz

about (Duration) one yrs. — mos. — ds.

Contributory Marital Conc.
Secondary

(Signed) James E. Welling, M. D.

July 28, 1914 (Address) 871 Harrison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL July 31, 1914

20 UNDERTAKER Girkler + Girkler ADDRESS 3204 O'Donnell

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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|--|---|---|--|
| 1 PLACE OF DEATH 6589 | | STATE OF MARYLAND | |
| County Baltimore | | CERTIFICATE OF DEATH | |
| Village or City W. Wilson, Md. | | Registration Dist. No. 31 | |
| 2 FULL NAME John Rosse | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX Male | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single | |
| 6 DATE OF BIRTH Unknown | | 16 DATE OF DEATH July 29th, 1914 | |
| (Month) (Day) (Year) | | (Month) (Day) (Year) | |
| 7 AGE 11 yrs. 11 mos. 11 ds. | If LESS than 1 day, hrs. OR min. ? | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Infant | | | |
| 9 BIRTHPLACE (State or country) Baltimore | | | |
| PARENTS | 10 NAME OF FATHER Sebastian Rosse | | |
| | 11 BIRTHPLACE OF FATHER (State or country) Unknown | | |
| | 12 MAIDEN NAME OF MOTHER Unknown | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) Unknown | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | |
| (Informant) W. Wilson, Md. | | | |
| (Address) Baltimore, Md. | | | |
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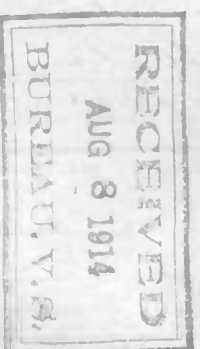
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traekia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6590

County

Baltimore

Village or City

Catonsville

(No.)

Spring Grove State Hospital

Registration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Alice Ruff

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE white
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH

Unknown Unknown, 1851
(Month) (Day) (Year)

7 AGE

63

yrs.

mos.

ds.

If LESS than
1 day.....hrs.
OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

John Mansley

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (State or country)

unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank F. Ruff

(Address)

Catonsville Md

15

Filed

July 25, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 24, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 1, 1891 to July 24, 1914

that I last saw her alive on July 24, 1914

and that death occurred on the date stated above, at 2²⁰ P. M.

The CAUSE OF DEATH* was as follows:

General Anasarca

(Duration) yrs. 1 mos. ds.

Contributory (Secondary)

Mitral Sufficiency

(Duration) 5 yrs. mos. ds.

(Signed)

J. Perry Wade

, M. D.

July 25, 1914 (Address) Catonsville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 28 yrs. 2 mos. 13 ds. In the State 63 yrs. mos. ds.

Where was disease contracted, Catonsville Md
If not at place of death?

Former or usual residence Catonsville Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lutheran Cemetery July 26, 1914

20 UNDERTAKER

ADDRESS

Mrs C. Piester Catonsville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—(*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH 6591 | | STATE OF MARYLAND | |
| County Baltimore | | CERTIFICATE OF DEATH | |
| Village or City (No. 104) Thos. Wilson, Md. | | Registration Dist. No. Sanitarium | |
| 2 FULL NAME Math Scanlon | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX Female | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single | |
| 6 DATE OF BIRTH Unknown | | | |
| 7 AGE 16 yrs. 16 mos. 16 ds. If LESS than 1 day, hrs. OR min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work Infant (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) Baltimore | | | |
| PARENTS | 10 NAME OF FATHER Daniel Scanlon | | |
| | 11 BIRTHPLACE OF FATHER (State or country) Unknown | | |
| | 12 MAIDEN NAME OF MOTHER Unknown | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) Unknown | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) John Wilson (Address) Thos. Wilson, Md. | | | |
| 15 Filed 2 , 191 4 REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH July 29th, 1914 (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from 1914 to 1914 , that I last saw him alive on 1914 , and that death occurred on the date stated above, at m. The CAUSE OF DEATH* was as follows: Ilitis Colicis (Duration) yrs. 1 mos. 1 ds. Contributory Fatty Liver (Duration) yrs. 2 mos. 2 ds. (Signed) John Wilson , M. D. July 29, 1914 (Address) Thos. Wilson, Md. | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. 20 mos. 20 ds. in the State yrs. 20 mos. 20 ds. Where was disease contracted, At home If not at place of death? Baltimore Former or usual residence Baltimore | | | |
| 19 PLACE OF BURIAL OR REMOVAL Unknown | | DATE OF BURIAL 1914 | |
| 20 UNDERTAKER Unknown | | ADDRESS | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

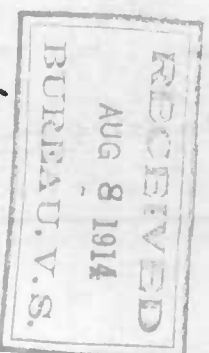
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telæmia*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Baltimore

6592

135

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

47

Village or City

Colgate

(No.)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Anna C. Schenning

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)*Married*

6 DATE OF BIRTH

*Nov.**20**1880*

(Month)

(Day)

(Year)

7 AGE

*33**8**1**ds.*

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

9 BIRTHPLACE

(State or country)

md.

PARENTS

10 NAME OF FATHER

Bernard Funcher

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Elizabeth Bennett

13 BIRTHPLACE OF MOTHER

(State or country)

md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Schenning

(Address)

29 S. Highland Ave

15

Filed

*July 23, 1914**W. E. McClure*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*July 21**1914*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

*July 21**1914*

to

*July 21**1914*

that I last saw him

or

alive on

*July 21**1914*and that death occurred on the date stated above, at *629* m.

The CAUSE OF DEATH* was as follows:

Post Partum Hemorrhage

(Duration)

yrs.

mos.

ds.

Contributory
Secondary

(Signed)

John S. Seale

(Duration)

yrs.

mos.

ds.

(Address)

3328 E. 1st St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Sacred Heart**July 24, 1914*

20 UNDERTAKER

Lilly and Ziehl

ADDRESS

403 S. M. 1st St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

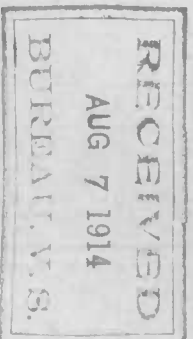
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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably*, such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6593

County BaltimoreVillage or City Boolgate (No. _____)

St.: _____ Ward) _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 412 FULL NAME Still BornSchenning

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 21, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. OR _____ min. ?
It LESS than 1 day, _____ hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Co Md.

10 NAME OF FATHER Henry Schenning

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna C. Funcher

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Schenning(Address) 29 S. Highland Ave.

15 Filed July 22, 1914 W. E. McClellan
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h. _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still Birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. S. Schenning, M. D.
July 22, 1914 (Address) 333 E. Pratt

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Sacred Heart Am. DATE OF BURIAL July 24, 1914

20 UNDERTAKER Lilly E. Ziehl ADDRESS 403 S. Wagon

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 6594
 County Baltimore
 Village or City Lansdowne (No. Post-Road St.; Ward)
2 FULL NAME Conrade Schisler
 Registration Dist. No. 43
 [It death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
6 DATE OF BIRTH May 15, 1898
 (Month) (Day) (Year)
7 AGE 66 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?
8 OCCUPATION
 (a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer)
9 BIRTHPLACE Baltimore Md
 (State or country)

PARENTS

10 NAME OF FATHER Conrade Schisler
11 BIRTHPLACE OF FATHER Germany
 (State or country)
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER Germany
 (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Johannah Crunoles

(Address) 946 Wisconsin St

15 Filed July 17, 1914 W. F. Clayton
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 16, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1914, to July 16, 1914.

that I last saw him alive on July 16, 1914

and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
 (Duration) 5 yrs. 0 mos. 0 ds.

Contributory Cardiac dilatation
 Secondary

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) Claud C. Smith, M. D.

July 16, 1914 (Address) Lansdowne, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore Cemetery **DATE OF BURIAL** July 19, 1914

20 UNDERTAKER Christ Miller **ADDRESS** 9334 Jefferson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

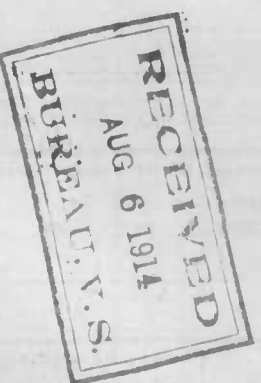
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

6595

Village or City

(No.

St.:

Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

mal

4 COLOR OR RACE

white

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

married

6 DATE OF BIRTH

July

0

1858

(Month)

(Day)

(Year)

7 AGE

55

yrs.

11

mos.

27

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Carriage Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md.

PARENTS

10 NAME OF FATHER

P. D. Schmidt

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Elizabeth H. Muhlen

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sam J. Schmidt

(Address)

Cokeysville Md.

15

Filed

, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

3

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 23

1914, to

July 3

1914

that I last saw him alive on

July 3

1914

and that death occurred on the date stated above, at

11:00

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Neoplasm -
+ Anemia

(Duration) 3 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

D. H. Busey

, M. D.

July 4, 1914 (Address) Texas, Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bruno Boar

July 6, 1914

20 UNDERTAKER

ADDRESS

A. H. Fuller

Baltimore

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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RECEIVED

AUG 5 1914

BUREAU U. S. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

6596

County

Baltimore

Village or City

Highlandtown (No. 243 S Third St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Katharine M. Schmitt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married. (Write the word).

6 DATE OF BIRTH

Dec. 12th, 1869 (Month) (Day) (Year)

7 AGE

44 yrs. 7 mos. 9 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

At home

9 BIRTHPLACE

(State or country)

Baltimore City

PARENTS

10 NAME OF FATHER

John M. Schmitt.

11 BIRTHPLACE OF FATHER (State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Susan Schmitt

13 BIRTHPLACE OF MOTHER (State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frederick M. Schmitt.

(Address)

243 S. Third St.

15

Filed

July 23, 1914 W. M. Clavahan

REGISTERED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 21st, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 10, 1914 to July 21, 1914 that I last saw her alive on July 19th, 1914

and that death occurred on the date stated above, at 9:25 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) J. A. Glantz, M. D.

July 22, 1914 (Address) 324 D. Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Oak Lawn Cem.

DATE OF BURIAL

July 24, 1914

20 UNDERTAKER

Tilly & Zeller

ADDRESS

403 S. Waverly

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

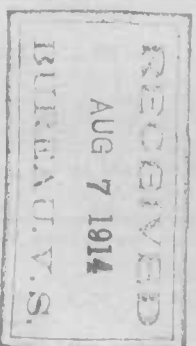
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercle of lungs, meningis, peritonaeum*, etc., *Carcin-*

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

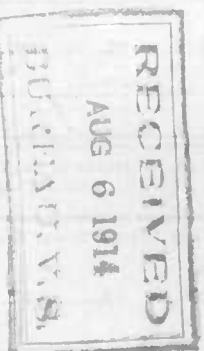
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' PLACE OF DEATH 6598

County Baltimore

(40)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 38Village or City Lanzeraville (No. Harford Road St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mrs. Louisa Scholz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Nov 8, 1858
(Month) (Day) (Year)

7 AGE 55 yrs. 8 mos. 11 ds. OR LESS than 1 day.....hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER John List
11 BIRTHPLACE OF FATHER (State or country) Europe
12 MAIDEN NAME OF MOTHER Catherine Bing
13 BIRTHPLACE OF MOTHER (State or country) Europe

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julia E. Kristensdoff(Address) Lanzeraville Rd.

15 Filed 191 Claud J. Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July 19th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 11th, 1914, to July 19th, 1914, that I last saw him alive on July 19th, 1914

and that death occurred on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma(Duration) 1 yrs. 2 mos. ds.Contributory Anaemia and
Secondary general debility(Duration) 1 yrs. 2 mos. ds.(Signed) Bennett Fargo, M. D.July 19, 1914. (Address) Maryland.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Emanuel Cemetery July 23rd, 1914

20 UNDERTAKER ADDRESS

Fredrick Roschke Fullerton Rd

If more blanks are needed, address State Registrar, 6 B. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

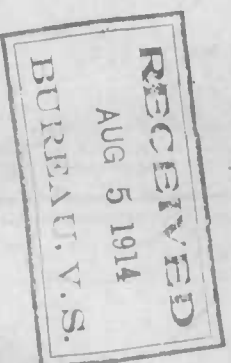
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

6599

(20)

County

Baltimore

Village or City

Calver

(No.)

Fustling Ave

St;

Ward)

Registered No.

30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William Thompson Seal

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

March 1, 1835
(Month) (Day) (Year)

7 AGE

79 yrs. 4 mos. ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Real Estate Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

Phila. Pa.

9 BIRTHPLACE (State or country)

Pennsylvania

PARENTS

10 NAME OF FATHER

Calib Seal

11 BIRTHPLACE OF FATHER (State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Lydia Thompson

13 BIRTHPLACE OF MOTHER (State or country)

Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr Alfred H. Seal

(Address)

400 Wister St. Germantown

15

Filed

July 26, 1914 Marshall B West

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 26, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 24, 1914, to July 26, 1914
that I last saw him alive on July 24, 1914

and that death occurred on the date stated above, at 5.05 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) ? yrs. ? mos. ? ds.
Contributory (Secondary) Nephritis poisoning

(Signed) E. H. Holbrook, M. D.
July 26, 1914 (Address) 732 Kensington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 0 yrs. 1 mos. ds. In the State 0 yrs. 1 mos. ds.
Where was disease contracted, Not known
If not at place of death?
Former or usual residence Phila Pa

19 PLACE OF BURIAL OR REMOVAL

Philadelphia Pa.

DATE OF BURIAL

July 26, 1914

20 UNDERTAKER

Stewart & Son Co

ADDRESS

15 W. Egan St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. 5. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*, *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality, as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 6, 1914

BUREAU U. S. S.

DATE OF BIRTH

ADDRESS

Revised by the American Medical Association

62847 10044

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | |
|--|-----------------------------------|---|--|
| 1 PLACE OF DEATH 6600 | | STATE OF MARYLAND | |
| County Baltimore | | CERTIFICATE OF DEATH | |
| Village or City Gorham (No. _____) | | Registration Dist. No. 38 | |
| 2 FULL NAME Mary Leving Sedgwick | | [If death occurred in hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX Female | 4 COLOR OR RACE Colored | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word) | |
| 6 DATE OF BIRTH 1861 (Month) (Day) (Year) | | | |
| 7 AGE 53 yrs. + mos. + ds. OR 1 day. + hrs. + min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. House work. (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) Balto | | | |
| PARENTS | | | |
| 10 NAME OF FATHER Don't know | | | |
| 11 BIRTHPLACE OF FATHER (State or country) Balto | | | |
| 12 MAIDEN NAME OF MOTHER Don't know | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) Balto | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Louis W. Hoffman (Address) Bellamy Ave. and Lakes | | | |
| 15 Filed 7/10 , 191 4 Chas. Smith REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH July 12 , 191 4 (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage / Apoplectic Stroke 2 months dead (Duration) yrs. mos. ds. | | | |
| Contributory Secondary | | | |
| (Signed) Chas. Smith, Coroner July 12, 1914 (Address) Laurieville Md. | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____ | | | |
| 19 PLACE OF BURIAL OR REMOVAL Mt Auburn | | DATE OF BURIAL July 14 , 191 4 | |
| 20 UNDERTAKER Robt J. Jones | | ADDRESS 1442 1/2 Bdey | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

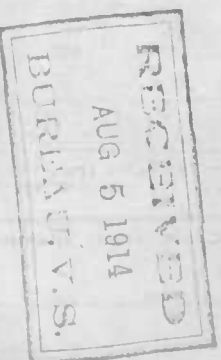
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **6601**
County Baltimore

Village or City Overlea (No. 79) St.; Ward

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 43

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George W. Seebold

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH 10 4, 1844
(Month) (Day) (Year)

7 AGE 69 yrs. 9 mos. 4 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Retired Packer
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER J. E. H. Seebold

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary A. Stein

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. F. Seebold

(Address) 146 Lakewood Ave

15 Filed July 8, 1914 W. H. Clayton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 8, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 8, 1914 to July 8, 1914
that I last saw him alive on July 8, 1914

and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) Same yrs. mos. ds.
Contributory Secondary

(Signed) W. H. Clayton, M. D.
July 8, 1914 (Address) Overlea

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Greenmount Cemetery DATE OF BURIAL July 12, 1914

20 UNDERTAKER Lubrick Bros & Son ADDRESS Gay Fullerton Rd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

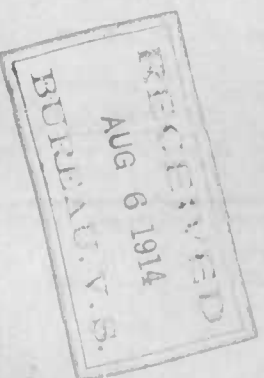
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

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1 PLACE OF DEATH

6602

(81)

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Brooks Hill

(No.)

5th Ave + Monumental Road

St.

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Marie Seidel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widow

6 DATE OF BIRTH

Aug 20th, 1832

7 AGE

81 yrs. 11 mos. ds.

11 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Germany

PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Smith

(Address)

5th Ave + Monumental Road

15

Filed

July 17, 1914, W. E. McLaughlin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 15, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1914, to July 15, 1914

that I last saw her alive on July 14, 1914

and that death occurred on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) 1 yrs. 6 mos. ds.

Contributory Secondary

Cerebral Hemorrhage

(Duration) yrs. 18 mos. ds.

(Signed)

W. J. McAvoy, M. D.

July 17, 1914 (Address) 839 S. Ellwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Prospect Hill Town

DATE OF BURIAL

July 18, 1914

20 UNDERTAKER

W. O. Philip Herwig

ADDRESS

2016 Orleans

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

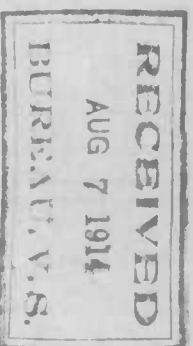
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 6603

County Balto.Village or City Catanville No. _____STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Seidlich

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH July 19, 1914
(Month) (Day) (Year)7 AGE _____
11 LESS than 1 day, _____ hrs. _____ yrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto. Co. Md.10 NAME OF FATHER Henry Seidlich11 BIRTHPLACE OF FATHER (State or country) Balto. Md.12 MAIDEN NAME OF MOTHER Mary Lyons13 BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Seidlich(Address) Catanville Md15 Filled July 20, 1914 Marshall B Wirt

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 19, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 19, 1914, to July 19, 1914, that I last saw him alive on, 1914.and that death occurred on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Premature birth
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Stultz, M. D.,
July 19, 1914. (Address) Catanville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Salem Lutheran DATE OF BURIAL July 20, 191420 UNDERTAKER Henry Seidlich ADDRESS Catanville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

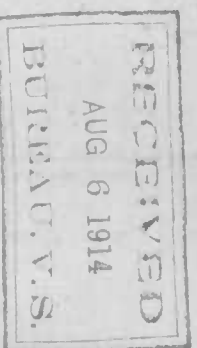
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1 PLACE OF DEATH

5604

County

Baltimore

Village or City

Sudbrook

(No.

St;

Ward)

Registered No.

32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Howell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

do not know, 1864

(Month)

(Day)

(Year)

7 AGE

50

yrs.

mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

do not know

PARENTS

10 NAME OF FATHER

do not know

11 BIRTHPLACE OF FATHER (State or country)

do not know

12 MAIDEN NAME OF MOTHER

do not know

13 BIRTHPLACE OF MOTHER (State or country)

do not know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lizzie Gross

(Address)

146 East St.

15

Filed

7/6/1914

1914

H. G. Naylor

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

7

4

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Raw disease

to

1914

that I last saw in

at home

1914

and that death occurred on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Natural Cause

Angina Pectoris

(Duration)

Immediate

yrs.

mos.

ds.

Contributory (Secondary)

Acute Indigestion

(Duration)

Few minutes

yrs.

mos.

ds.

(Signed)

H. G. Naylor

M. D.

7/6/1914

(Address)

Pikesville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union Cemetery

7/7/1914

ADDRESS

20 UNDERTAKER

J. H. Kray

Pikesville Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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RECEIVED
AUG 6 1914
BUREAU, U. S.

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| | | | | |
|--|---------------------------------|---|--|----------------------------------|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 6605 | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Baltimore</u> (No. <u>for Consumption Home</u>) | | St.; _____ Ward _____ | | Registration Dist. No. <u>33</u> |
| 2 FULL NAME <u>Mrs. Sarah Sigel</u> | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX <u>7</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word) | | |
| 6 DATE OF BIRTH <u>unknown</u> , 18 <u>76</u> (Month) (Day) (Year) | | | | |
| 7 AGE <u>38</u> yrs. _____ mos. _____ ds. | | It LESS than 1 day, _____ hrs. OR _____ min. ? | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | |
| 9 BIRTHPLACE (State or country) <u>Russia</u> | | | | |
| PARENTS | | | | |
| 10 NAME OF FATHER <u>unknown</u> | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Russia</u> | | | | |
| 12 MAIDEN NAME OF MOTHER <u>unknown</u> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Russia</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jack Cohen M.D.</u> (Address) <u>for Consumption Home</u> | | | | |
| 15 <u>July 2</u> , 191 <u>4</u> <u>15 M Street</u> Filed <u>July 7</u> , 191 <u>4</u> <u>15 M Street</u> | | | | |
| REGISTRAR | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | |
| 16 DATE OF DEATH <u>July</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>June 3</u> , 191 <u>3</u> , to <u>July 1</u> , 191 <u>4</u> , that I last saw her alive on <u>July 1</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>9:10 P.</u> m. | | | | |
| The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u> | | | | |
| (Duration) <u>5</u> yrs. <u>4</u> mos. _____ ds. | | | | |
| Contributory _____ Secondary _____ | | | | |
| (Duration) _____ yrs. _____ mos. _____ ds. | | | | |
| (Signed) <u>Jack Cohen</u> , M. D. <u>July 2</u> , 191 <u>4</u> (Address) <u>for Con. Home</u> | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | |
| 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death <u>1</u> yrs. <u>1</u> mos. _____ ds. In the State <u>16</u> yrs. _____ mos. _____ ds. Where was disease contracted, <u>Baltimore</u> If not at place of death? _____ Former or usual residence <u>864 Grand St.</u> | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Baltimore Hebrew Cemetery</u> | | | DATE OF BURIAL <u>July 2</u> , 191 <u>4</u> | |
| 20 UNDERTAKER <u>M. L. Lerman, S.</u> | | | ADDRESS <u>1107 E. Balto. St.</u> | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

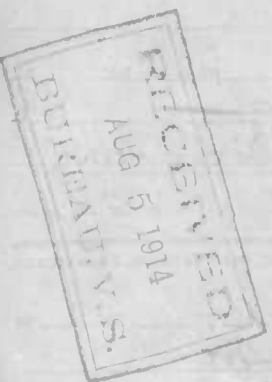
[Approved by U. S. Census and American Public Health Association.]

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¹ PLACE OF DEATH 6606
County Baltimore

Village or City Catonsville (No. Spring Grove S. R. St.; Ward)

Registration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME Marie E. Sinclair

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Female ⁴ COLOR OR RACE white ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

⁶ DATE OF BIRTH Aug 20, 1861
(Month) (Day) (Year)

⁷ AGE 53 yrs. 10 mos. 10 ds. If LESS than 1 day, hrs. OR min. ?

⁸ OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Maryland

¹⁰ NAME OF FATHER Abner Rowe

¹¹ BIRTHPLACE OF FATHER (State or country) Maryland

¹² MAIDEN NAME OF MOTHER Ellen Smith

¹³ BIRTHPLACE OF MOTHER (State or country) Maryland

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. E. Sinclair

(Address) Telghuanis Island, Md.

¹⁵ July 20, 1914 Marshall B. Broth

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

(68)

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH July 20, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY that I attended deceased from Feb 23rd, 1914, to July 20, 1914, that I last saw her alive on July 20, 1914, and that death occurred on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Exhaustion

Contributory (Secondary) Molecular Melancholia
(Duration) yrs. mos. ds.

(Signed) Herbert C. M., M. D.
July 20, 1914 (Address) Catonsville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted If not at place of death?

Former or usual residence Salisbury, Md.

¹⁹ PLACE OF BURIAL OR REMOVAL Alphamary Island DATE OF BURIAL July 20, 1914

²⁰ UNDERTAKER Herbert C. M. ADDRESS 413 2nd Street, N.W., Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

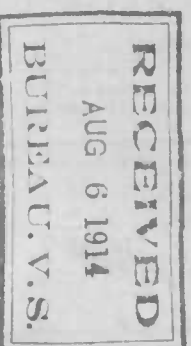
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—(naming, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6607

County BaltimoreVillage or City St. Agnes Hospital (No. 19)Registration Dist. No. 42St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mr. Carlton Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Nov. 2, 1865
(Month) (Day) (Year)

7 AGE 48 yrs. 7 mos. ds. OR min. ?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Baggage Master
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Harry Smith

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lavinia Usher

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. U. Smith(Address) St. Denis, Md.

15 Filed July 7, 1914 F. W. A. Stewart
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 2, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1914, to July 2, 1914, that I last saw him alive on July 2, 1914

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) 2 yrs. mos. ds.

Contributory Acute dilatation of
Secondary Heart.

(Signed) Walter A. Ostrander, M. D.

July 2, 1914 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence St. Louis, Mo.

19 PLACE OF BURIAL OR REMOVAL London Cemetery DATE OF BURIAL July 5, 1914

20 UNDERTAKER Techum & San Remo & North ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

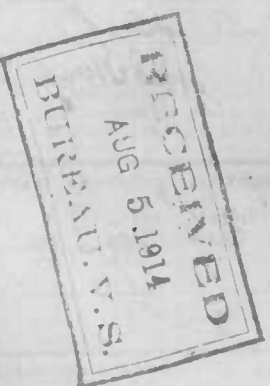
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH **6608**
County Baltimore

Village or City St. Louis (No. _____, St.; _____ Ward)

2 FULL NAME Rev. Solovey

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Unknown

6 DATE OF BIRTH Unknown, 1 _____ (Month) (Day) (Year)

7 AGE Unknown If LESS than 1 day, _____ hrs. _____ yrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Unknown (b) General nature of industry, business, or establishment in which employed (or employer) Unknown

9 BIRTHPLACE (State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. Gross

(Address) St. Louis, Mo.

15 Filed July 15, 1914 F. H. Ruhl
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m,

The CAUSE OF DEATH* was as follows:

Accidental, due to being run over by St. Louis & Baltimore 13th St. Balto Co. Mo.
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Signed) Samuel L. Bougeholder, M. D.
July 14, 1914 (Address) St. Louis, Mo.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) Unknown

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mount Zion July 15, 1914
20 UNDERTAKER ADDRESS

Ruell & Son 1729 W Pratt St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH **6669**
County Baltimore

Village or City Pikesville (No. _____, _____ St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Evelyn Stansbury

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 11 10 1901
(Month) (Day) (Year)

7 AGE 12 yrs. 10 mos. 14 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. School girl
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Balt. Co.

PARENTS
10 NAME OF FATHER Corroll C. Stansbury
11 BIRTHPLACE OF FATHER (State or country) Balt. Co.
12 MAIDEN NAME OF MOTHER Sarah P. Brooks
13 BIRTHPLACE OF MOTHER (State or country) Balt. Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Corroll C. Stansbury
(Address) Pikesville

15 Filed July 25th 1914 Henry A. Naylor
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July 24, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1914, to July 24, 1914, that I last saw him alive on July 24, 1914, and that death occurred on the date stated above, at 5:30 P. M., The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) _____ yrs. _____ mos. 1 ds.

Contributory Acute Gastritis
(Secondary)

(Duration) _____ yrs. _____ mos. 3 ds.

(Signed) Henry A. Naylor, M. D.
July 25, 1914 (Address) Pikesville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL David Ridge DATE OF BURIAL July 27, 1914

20 UNDERTAKER C. H. Kraft ADDRESS Pikesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

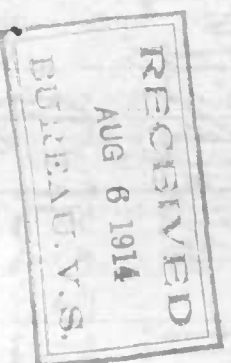
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not rainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6610

County

Baltimore

Village or City

Middle River

(No.)

St.

Ward)

Registration Dist. No.

48

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Steel born unpaired Staten

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

Cal

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

July 28, 1910

(Month) (Day) (Year)

7 AGE

000

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Ind

PARENTS

10 NAME OF FATHER

James Staten

11 BIRTHPLACE OF FATHER

(State or country)

Ind

12 MAIDEN NAME OF MOTHER

Sarah Gaines

13 BIRTHPLACE OF MOTHER

(State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Staten

(Address)

Middle River, Ind

15

Filed

July 28, 1910 of W. S. T. M. W. S.

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 28, 1910

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191,

that I last saw him alive on , 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Steel born

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) John W. Haines M. D.

July 28, 1910 (Address) Middle River

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoop St Cem July 29, 1910

20 UNDERTAKER

ADDRESS

Chas. F. S. Ross

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto.—Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

6611

County

Baltimore

Village or City

Cattington Potomac Ave

(No.)

Registration Dist. No.

32

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Carrall Stewart

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

March 25, 1909

(Month)

(Day)

(Year)

7 AGE

5 yrs. 4 mos. 0 ds.

 1 LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Baltimore - Co

10 NAME OF FATHER

Webster Stewart

11 BIRTHPLACE OF FATHER (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Eva B. Harris

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. L. Stewart

(Address)

Sta. E. City

15

Filed

July 26, 1914 Wm. H. Queen

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 25, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY that I attended deceased from

July 25, 1914, to July 25, 1914

that I last saw him alive on July 25, 1914,

and that death occurred on the date stated above, at 12:22 m.

The CAUSE OF DEATH was as follows:

Typhoid Fever

(Duration) yrs. mos. 12 ds.

Contributory (Secondary)

Contributory (Secondary)

(Signed)

H. F. Haines, M. D.
July 25, 1914 (Address) Sta. E. City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery July 27, 1914

20 UNDERTAKER

ADDRESS

Wm. Cook 502 E. Han

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative *jealithfulness* of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinster*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tandition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 6 1914
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | | | | |
|---|--|---------------------------------|--|--|--|---|--|
| 1 PLACE OF DEATH County <u>Balto</u> | | 6612 | | 154 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Balto Co - Alms House</u> | | No. <u>154</u> | | St.; Ward | | Registration Dist. No. <u>37</u> | |
| 2 FULL NAME <u>William Stewart</u> | | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | |
| 3 SEX <u>male</u> | | 4 COLOR OR RACE <u>negro</u> | | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word) | | | |
| 6 DATE OF BIRTH <u>unknown</u> (Month) (Day) (Year) | | | | | | | |
| 7 AGE <u>about 69</u> yrs. mos. ds. | | | | It LESS than 1 day, hrs. OR min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | | | |
| 9 BIRTHPLACE (State or country) <u>Virginia</u> | | | | | | | |
| PARENTS | 10 NAME OF FATHER <u>unknown</u> | | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>unknown</u> | | | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>unknown</u> | | | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>unknown</u> | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Alms House Record</u> (Address) <u>Texas Md</u> | | | | | | | |
| 15 Filed <u>July 15, 1914</u> <u>B. R. Benson</u> REGISTRAR <u>Deputy</u> | | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | |
| 16 DATE OF DEATH <u>July 15, 1914</u> (Month) (Day) (Year) | | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 1, 1914</u> , to <u>July 15, 1914</u> , that I last saw him alive on <u>July 10, 1914</u> , and that death occurred on the date stated above, at <u>a</u> m. | | | | | | | |
| The CAUSE OF DEATH* was as follows: <u>recus of leg</u> <u>senility</u> (Duration) yrs. mos. ds. | | | | | | | |
| Contributory Secondary (Duration) yrs. mos. ds. | | | | | | | |
| (Signed) <u>B. R. Benson</u> , M. D. <u>July 15, 1914</u> (Address) <u>Cockey Hall Md</u> | | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. in the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Board of Anatomy</u> | | | | DATE OF BURIAL <u>July 15, 1914</u> | | | |
| UNDERTAKER <u>Christian Miller</u> | | | | ADDRESS <u>Montford ave and Jefferson Str</u> | | | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

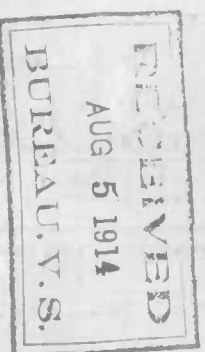
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **6613**
County Baltimore

Village or City Barton (No. 1457, S. Clinton St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John W. Stine, Jr.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 19, 1912
(Month) (Day) (Year)

7 AGE 2 yrs. 2 mos. 2 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John W. Stine, Sr.

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie V. Bray

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Stine

(Address) 1457 S. Clinton

15 July 22, 1914 W. M. Clavell
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July 21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 10th, 1914, to July 21, 1914, that I last saw him alive on July 21, 1914

and that death occurred on the date stated above, at 4:50 p. m.
The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

Contributory (Duration) 11 yrs. 11 mos. 11 ds.
Secondary Exhaustion

(Signed) David W. Jones, M. D.
July 21, 1914 (Address) 3116 O'Donnell St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Trinity Cemetery DATE OF BURIAL July 22, 1914

20 UNDERTAKER W. D. Zirkler + Zirkler ADDRESS 3204 O'Donnell

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

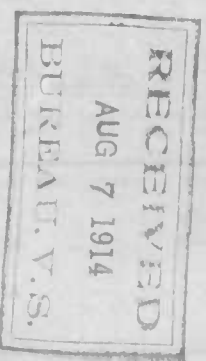
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 6614

County BaltimoreVillage or City St. Agnes Hospital (No. 120)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mrs. Cecilia Strosser

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|------------------------|---------------------------------|---|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>Widowed</u> |
|------------------------|---------------------------------|---|

6 DATE OF BIRTH March, 1866
(Month) (Day) (Year)7 AGE 48 yrs. 3 mos. - ds. OR LESS than 1 day, - hrs. - min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Europe10 NAME OF FATHER Antonia Konoway11 BIRTHPLACE OF FATHER (State or country) Europe12 MAIDEN NAME OF MOTHER Cecilia13 BIRTHPLACE OF MOTHER (State or country) Europe

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nicholas Strosser(Address) 2444 Frederick Ave15 Filed July 6, 1914 G. W. Stewart
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 3, 1914, to July 6, 1914, that I last saw her alive on July 6, 1914and that death occurred on the date stated above, at 2:10 a.m.
The CAUSE OF DEATH* was as follows:Chronic Interstitial
nephritis
(Duration) 8 yrs. - mos. - ds.Contributory Uremia
Secondary
(Duration) - yrs. - mos. 1 ds.(Signed) Walter G. Schneider, M. D.
July 6, 1914 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death - yrs. - mos. 3 ds. In the State - yrs. - mos. - ds.

Where was disease contracted, If not at place of death?

Former or usual residence 2444 Frederick Ave19 PLACE OF BURIAL OR REMOVAL Our Cathedral DATE OF BURIAL July 9, 191420 UNDERTAKER Wm Cook ADDRESS North Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

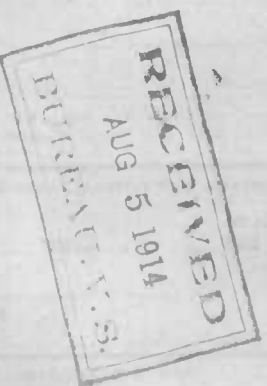
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 6615
County Baltimore

Village or City Pikeville (No. 79) St; Ward

2 FULL NAME Richard B. Stubbs

Registered No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower
(Write the word)

6 DATE OF BIRTH 2 14 1886
(Month) (Day) (Year)

7 AGE 28 yrs. 5 mos. 15 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Canner
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Bald City

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (State or country) Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. A. Corboe

(Address) Pikeville

15 Filed 7/30 1914 Henry G. Mayhew
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 29 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from for many years 1914,
that I last saw him alive on July 28 1914

and that death occurred on the date stated above, at 12:5 P. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease with dilatation

(Duration) unknown yrs. mos. ds.
Contributory Smoking (Secondary)

(Signed) W. O. M. J. M. D.
7-29 1914 (Address) Pikeville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Louden Park DATE OF BURIAL July 31 1914

20 UNDERTAKER C. H. Kraft ADDRESS Pikeville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

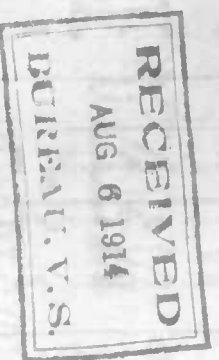
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH **6616**
 County Baltimore
 Village or City Thos Wilson Sanitarium (No. 104)
M. K. Wilson, Md. St. Wd. Ward
 2 FULL NAME Alberta Thomas
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
 4 COLOR OR RACE White
 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
 6 DATE OF BIRTH Unknown
 (Month) (Day) (Year)

7 AGE 4 yrs. 4 mos. 4 ds. OR 1 day, 4 hrs. 4 min. ?
 If LESS than 1 day, hrs. min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Infant
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

PARENTS
 10 NAME OF FATHER Frank Thomas
 11 BIRTHPLACE OF FATHER (State or country) Unknown
 12 MAIDEN NAME OF MOTHER Unknown
 13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. K. Wilson Jr.
 (Address) Mt Wilson, Md.

15 Filed 9, 1914
 REGISTRAR

STATE OF MARYLAND
 CERTIFICATE OF DEATH
 Registration Dist. No. 31

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Castro. Infect Intoxication
 (Duration) 21 yrs. 21 mos. 21 ds.

Contributory Secondary

(Signed) J. M. K. Wilson Jr., M. D.
July 14, 1914. (Address) Mt Wilson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death 5 yrs. 5 mos. 5 ds. In the State 5 yrs. 5 mos. 5 ds.

Where was disease contracted, At home

If not at place of death? Baltimore

Former or usual residence Baltimore

19 PLACE OF BURIAL OR REMOVAL Unknown DATE OF BURIAL 191

20 UNDERTAKER Unknown ADDRESS Unknown

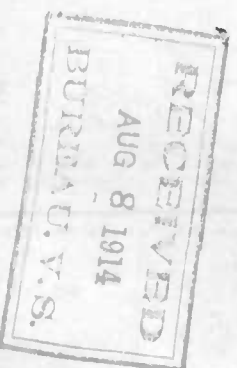
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6617

County

Baltimore

Village or City

(No.

Thos. Wilson Sanatorium
Mt. Union, Md.

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Gordon Thompson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Unknown

7 AGE

5 wks.

It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Unknown

PARENTS

10 NAME OF FATHER

Joseph Thompson

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. K. Jr.

(Address)

Mt. Union, Md.

15

Filed

191

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 11th, 1914

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Dys Colitis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

J. M. K. Jr.

M. D.

July 11, 1914 (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 17 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

At home

Former or usual residence

Baltimore

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Unknown

191

20 UNDERTAKER

ADDRESS

Unknown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

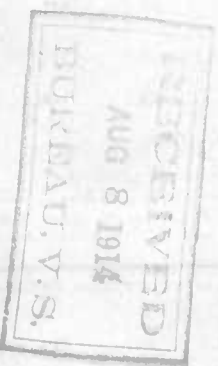
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| | | | | | |
|--|-----------------------------------|---|--|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 6618 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Roslyn</u> | | (No.) | | Registered No. <u>34</u> | |
| 2 FULL NAME <u>Infant child of Martha Piffman</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | | | |
| 6 DATE OF BIRTH <u>7</u> <u>12</u> , 19 <u>14</u> (Month) (Day) (Year) | | | | | |
| 7 AGE yrs. mos. ds. If LESS than 1 day, hrs. min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Balt. Co. Md</u> | | | | | |
| PARENTS | | | | | |
| 10 NAME OF FATHER <u>Unknown</u> | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> | | | | | |
| 12 MAIDEN NAME OF MOTHER <u>Martha Campbell</u> | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Balt. Co.</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Roosevelt Piffman</u> (Address) <u>Roslyn</u> | | | | | |
| 15 Filed <u>7/13/1914</u> <u>H. M. G. Naylor</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>7</u> <u>12</u> , 19 <u>14</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>7/12/14</u> , 19 <u>14</u> , to <u>7/12/14</u> , 19 <u>14</u> , that I last saw him <u>in dead</u> alive on <u>7/12/14</u> , 19 <u>14</u> , and that death occurred on the date stated above, at <u>7 P</u> m. The CAUSE OF DEATH* was as follows: <u>Still Birth</u> <u>Had been dead several days before birth</u> (Duration) yrs. mos. ds. | | | | | |
| Contributory (Secondary) | | | | | |
| (Signed) <u>M. D.</u> <u>7/13/14</u> , 19 <u>14</u> (Address) <u>Washington</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. to the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Union Cemetery</u> DATE OF BURIAL <u>July 14</u> , 19 <u>14</u> | | | | | |
| 20 UNDERTAKER <u>Ed. H. Neft</u> ADDRESS <u>Pikesville</u> | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

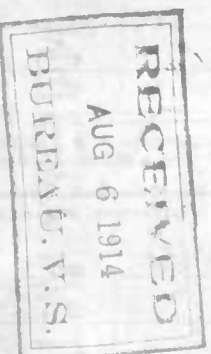
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on Nomenclature of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 6619

County

Balt

(81)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 33

Village or City

Woodensburg

(No.)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Caleb Uhler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

unwed

6 DATE OF BIRTH

8

7

1824

(Month)

(Day)

(Year)

7 AGE

89

yrs.

10

mos.

2.5

ds.

If LESS than
1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

Conrad Uhler

11 BIRTHPLACE OF FATHER (State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (State or country)

unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. C. Hagar

(Address)

Woodensburg

15

Filed

July 27, 1914

Jas. H. Wilson M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

7

26

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

off and on for several years, 1911

that I last saw him alive on July 23rd, 1914

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Chorea incident to old age
Arterio-sclerosis

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Arterio-sclerosis

(Duration)

yrs.

mos.

ds.

(Signed)

Jas. H. Wilson

M. D.

1914

(Address)

Fowlesburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

yrs.

mos.

ds.

to the

State

yrs.

mos.

ds.

Where was disease contracted, If out at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Liliad

July 28th, 1914

20 UNDERTAKER

ADDRESS

Joseph J. Eline

Reisterstown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH Balto 6620 175
 County Balto
 Village or City En v. R. (No. _____, _____ St.; _____ Ward)
 2 FULL NAME Benj. Vain
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE w 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Feb 12, 1888
 (Month) (Day) (Year)

7 AGE 26 yrs. 5 mos. 7 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work. Blackston
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER John Vain

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Schonst

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Vain

(Address) 1920 Fairmount Ave

15 July 19, 1914 W. E. McLaughlin
 File _____ REGISTRAR M. S.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 19, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw h. _____ alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Fracture Skull
fall from Wagon
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
 Secondary _____

(Signed) A. S. Mupier, M. D.
July 19, 1914 (Address) Co. 101

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL July 19, 1914

20 UNDERTAKER Constance Miller ADDRESS 2334 Jefferson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH *Balto. County* 5621
 County *Highlandtown* STATE OF MARYLAND
 CERTIFICATE OF DEATH

Village or City *Highlandtown* (No. *3222 Fair Ave*) Registration Dist. No. *41* St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Albert P Vincent*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDDED, OR DIVORCED *single*
 (Write the word)

6 DATE OF BIRTH *April 24*, 1890
 (Month) (Day) (Year)

7 AGE *24* yrs. mos. ds. OR *1* day, hrs. min. ?
 If LESS than 1 day, hrs. min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work *Labor*
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Md.*

10 NAME OF FATHER *Harry Vincent*

11 BIRTHPLACE OF FATHER (State or country) *Md.*

12 MAIDEN NAME OF MOTHER *Mary Law*

13 BIRTHPLACE OF MOTHER (State or country) *Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mary Vincent*

(Address) *3222 Fair Ave*

15 Filed *July 23*, 1914 *W. E. McClanahan*
 4 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 21*, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *July 11*, 1914, to *July 21*, 1914
 that I last saw him alive on *July 21*, 1914

and that death occurred on the date stated above, at *420a* m.
 The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. mos. ds.

Contributory *Menstruation*
 Secondary *1 hour* (Duration) yrs. mos. ds.

(Signed) *W. L. Burke*, M. D.
 , 191 (Address) *3042 Hudson St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Washed and buried July 24, 1914
 20 UNDERTAKER ADDRESS *John A. Moran & Am*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

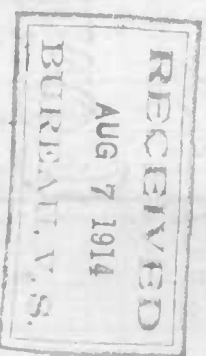
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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County

Baltimore

Village or City

Arlington

(No.

Newton Ave.

St;

Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No.

32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles Vogelsang

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Feb 27 1914
(Month) (Day) (Year)

7 AGE

— yrs. 5 mos. 4 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Arlington Md

PARENTS

10 NAME OF FATHER

Fred Vogelsang

11 BIRTHPLACE OF FATHER
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary Lowe

13 BIRTHPLACE OF MOTHER
(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Fred Vogelsang

(Address)

Newton Ave. Md.

15

Filed

Aug 1 1914 William G. Owen
Arlington Md. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 31 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 28 1914, to July 31 1914

that I last saw him alive on

July 31 1914

and that death occurred on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

whooping cough

(Duration) 5 weeks

Contributory
(Secondary)

Illness - Colitis

(Duration) 4 ds.

(Signed)

C. B. Enos

M. D.

8-1-

1914

(Address)

Arlington Md

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At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McKendric Cemetery Arlington Aug 1, 1914

20 UNDERTAKER

ADDRESS

Chenoweth & Son 3615 Chesnut Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 da.; *Bronchopneumonia* (secondary), 10 da. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

6623 (This was mislaid by some one & sent it now)

1 PLACE OF DEATH STATE OF MARYLAND
CERTIFICATE OF DEATH
 County Baltimore Registered No. 40
 Village or City Rossville (No. 69) St. Ward [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John W. Walsh

| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | |
|--|--|--|---|--|
| 3 SEX <u>male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDDED, DIVORCED (Write the word) <u>married</u> | 16 DATE OF DEATH <u>July 19, 1914</u> (Month) (Day) (Year) | 17 I HEREBY CERTIFY, That I attended deceased from <u> </u> , 191 <u> </u> , to <u> </u> , 191 <u> </u> , that I last saw him alive on <u> </u> , 191 <u> </u> , and that death occurred on the date stated above, at <u> </u> m. The CAUSE OF DEATH* was as follows: <u>Accidentally drowned</u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. |
| 6 DATE OF BIRTH <u> </u> , 188 <u>3</u> (Month) (Day) (Year) | | | Contributory (Secondary) <u> </u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. | |
| 7 AGE <u>31</u> yrs. <u> </u> mos. <u> </u> ds. OR <u> </u> min. ? If LESS than 1 day, <u> </u> hrs. | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Clerk</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Government service</u> | | | (Signed) <u>Frank F. Goulke coronr</u> <u>July 19, 1914</u> (Address) <u>Rossville, Md</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | | | |
| PARENTS | 10 NAME OF FATHER <u>John W. Walsh</u> | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u> </u> | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> | | | |
| | 12 MAIDEN NAME OF MOTHER <u>not known</u> | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> | | 19 PLACE OF BURIAL OR REMOVAL <u>Cathedral Ave</u> | | DATE OF BURIAL <u>7/21, 1914</u> |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>William M. Rebel</u> (Address) <u>1812 N. Washington</u> | | | 20 UNDERTAKER <u>Chas. P. Evans Son</u> <u>18 Wm. Royal</u> | |
| 15 Filed <u>July 19, 1914</u> <u>J. W. T. Austin</u> <u>WR</u> REGISTRAR | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

we

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

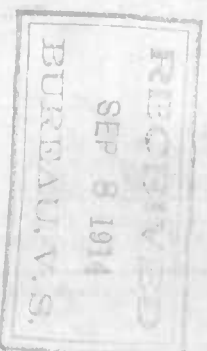
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the misadventure causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the misadventure causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **6624**
 County **Baltimore**
 Village or City **Hillsdale** (No. **Kernan Hosp.**) St. **Ward** (If death occurred in a hospital or institution, give its NAME instead of street and number.)
 2 FULL NAME **Robert H. Warner**

MEDICAL CERTIFICATE OF DEATH

| PERSONAL AND STATISTICAL PARTICULARS | | | |
|--|---|--|--|
| 3 SEX male | 4 COLOR OR RACE white | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word) | |
| 6 DATE OF BIRTH Apr. 5, 1913 (Month) (Day) (Year) | | | |
| 7 AGE 1 yrs. 3 mos. 3 ds. | | If LESS than 1 day, hrs. OR min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) N.C. | | | |
| PARENTS | 10 NAME OF FATHER Robert H. Warner | | |
| | 11 BIRTHPLACE OF FATHER (State or country) N.C. | | |
| | 12 MAIDEN NAME OF MOTHER Rosa Phillips | | |
| 13 BIRTHPLACE OF MOTHER (State or country) N.C. | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Record Kernan Hospital (Address) Hillsdale | | | |
| 15 Filed July 8, 1914 A. C. Smith REGISTRAR | | | |

| | |
|--|---------------------------------------|
| 16 DATE OF DEATH July 5, 1914 (Month) (Day) (Year) | |
| 17 I HEREBY CERTIFY, That I attended deceased from 6-3 , 1914 to 7-5 , 1914, that I last saw him alive on 7-4 , 1914, and that death occurred on the date stated above, at 2:15 a.m. , The CAUSE OF DEATH* was as follows: Tuberculosis of Left Hip Otitis Media (Duration) yrs. 10 mos. ds. Contributory Asthma Secondary (Duration) yrs. mos. ds. (Signed) W. B. Hunter , M. D. 7-5 , 1914 (Address) Kernan Hospital, Balto. | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. 3 mos. 15 ds. In the State yrs. 3 mos. 15 ds. Where was disease contracted, Raleigh, N.C. If not at place of death? Former or usual residence Raleigh, N.C. | |
| 19 PLACE OF BURIAL OR REMOVAL Raleigh N.C. | DATE OF BURIAL July 6, 1914 |
| 20 UNDERTAKER Jos B. Cook | ADDRESS Balto. Md. |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

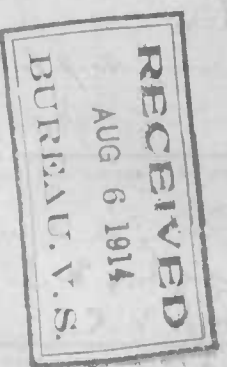
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is ~~not~~ definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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5625

104

1 PLACE OF DEATH Baltimore
 County Baltimore
 Village or City Poplar Heights No. 104 St. Ward
 2 FULL NAME Alice Virginia Watkins
 Registration Dist. No. 44
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Dec 7th, 1913
 (Month) (Day) (Year)

7 AGE 7 yrs. 9 mos. 9 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work none
 (b) General nature of Industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Balto. Co. Md

10 NAME OF FATHER Irvin Watkins

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Elvora Watkins

13 BIRTHPLACE OF MOTHER (State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Irvin Watkins
 (Address) Poplar Heights Balto Co

15 Filed July 17, 1914 G. McComick
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 16th, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from July 12th, 1914 to July 16, 1914
 that I last saw her alive on July 16th, 1914

and that death occurred on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) 6 yrs. mos. ds.

Contributory Exhaustion
 Secondary

(Duration) 2 yrs. mos. ds.

(Signed) G. McComick, M. D.

July 17, 1914 (Address) Spanners Point

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, it not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Asbury Cemetery DATE OF BURIAL July 19, 1914

20 UNDERTAKER July B. Pye ADDRESS Balto. Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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W. C. MORMICK, M.D.

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1 PLACE OF DEATH

County

Baltimore

6626

(28)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

31

Village or City

Woodlawn

(No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Sally Bell With

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

6 DATE OF BIRTH

Sept 181850

(Month)

(Day)

(Year)

7 AGE

63108ds.

If LESS than

1 day, _____ hrs.

OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

R. H. Worthington

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Shipley

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emma Pitts

(Address)

Woodlawn, Md

15

Filed

July 26, 1914H. F. Shipley

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 261914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 251914

to

July 261914

that I last saw him alive on

July 251914

and that death occurred on the date stated above, at

5:30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary TuberculosisFrom History (Duration) 3 yrs. — mos. — ds.

Contributory

Secondary

Exhaustion

(Duration)

_____ yrs.

1 mos.10 ds.

(Signed)

H. F. Shipley

, M. D.

July 26, 1914

(Address)

Baltimore, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds.

In the

State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Diamond Ridge, AnnapolisJuly 27, 1914

20 UNDERTAKER

ADDRESS

J. H. KraftPikesville, Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

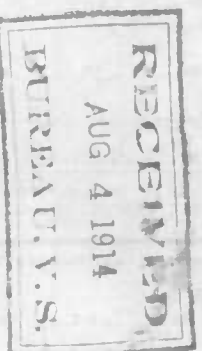
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Freeze statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

6627

County Balto. Md.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 42.

Village or City

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Infant

6 DATE OF BIRTH

June 29, 1914
(Month) (Day) (Year)

7 AGE

about 4 wks. yrs. mos. ds. OR min. ?
If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore

PARENTS

10 NAME OF FATHER

do not know

11 BIRTHPLACE OF FATHER

(State or country)

do not know

12 MAIDEN NAME OF MOTHER

do not know

13 BIRTHPLACE OF MOTHER

(State or country)

do not know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

St. Vincent St. Paul Soc

15

Filed July 21, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 18, 1914, to July 21, 1914
that I last saw him alive on July 20, 1914and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Swamian

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

Geo. Stewart

M. D.

July 21, 1914 (Address) St. Agnes' Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Peter Cemetery July 22, 1914

20 UNDERTAKER

ADDRESS

Wm. M. Gault 901 W. North St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

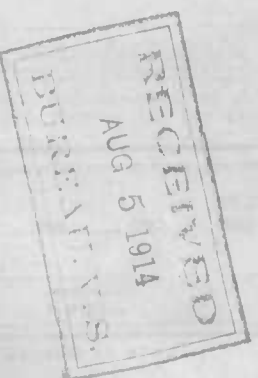
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6628
County Balto.
Village or City Brooklandville
2 FULL NAME Robert Wells
St. John T. Hopkins Ward) Acting Coroner
Registration Dist. No. 38
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|---|---|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u> |
| 6 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year) | | |
| 7 AGE <u>about 60</u> yrs. mos. ds. OR min. ? If LESS than 1 day, hrs. | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | |
| 9 BIRTHPLACE (State or country) <u>Unknown</u> | | |
| PARENTS | 10 NAME OF FATHER <u>"</u> | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>"</u> | |
| | 12 MAIDEN NAME OF MOTHER <u>"</u> | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>"</u> | |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

6/141914Claude Smink

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,
that I last saw h_____ alive on _____, 191____,
and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Heat Exhaustion
Apoplectic
Contributory Afflectic Stroke
Secondary
(Duration) yrs. mos. ds.
X Claud Smink Coroner
(Signed) July 14, 1914 (Address) Lauraville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Zion Cemetery7-15-1914

20 UNDERTAKER

ADDRESS

Shade Bros. Long Green

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

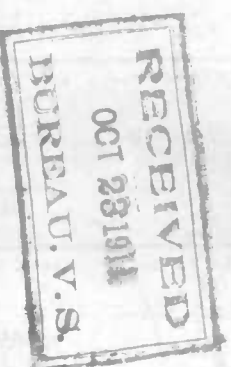
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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*sent out to be signed
in ink.*

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1 PLACE OF DEATH 6629
County Baltimore
Village or City Highstreet (No. 3702) St. Paul Ward
2 FULL NAME Grace
Registered No. 41
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|---|--|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> |
| 6 DATE OF BIRTH <u>July 8, 1918</u> (Month) (Day) (Year) | | |
| 7 AGE ____ yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. ____ min. ? <u>0</u> | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u> | | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | |
| PARENTS | 10 NAME OF FATHER <u>Samuel</u> | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u> | |
| | 12 MAIDEN NAME OF MOTHER <u>Mary Martin</u> | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Ireland</u> | | |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

July 11, 1918

REGISTERED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 8, 1918
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 8, 1918 to July 8, 1918
that I last saw him alive on July 8, 1918

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

Dr. Schuler, M. D.
July 8, 1918 (Address) 3307 E. Park St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

John Hopkins July 8, 1918

20 UNDERTAKER

ADDRESS

John Hopkins
John Hopkins

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 7 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 6630
County Baltimore

Village or City Pikesville (No. 182) Gaylor Lane St.; _____ Ward)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Alice Whiting

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, ☒ MARRIED, ☒ WIDOWED, ☒ OR DIVORCED (Write the word)

6 DATE OF BIRTH Unknown, 1 _____ (Month) (Day) (Year)

7 AGE about 19 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ mo. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Waitress (b) General nature of industry, business, or establishment in which employed Major Randolph Barton

9 BIRTHPLACE (State or country) Monrovia

10 NAME OF FATHER Wm Whiting

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Randolph Barton
(Address) Pikesville PO

15 Filed July 14, 1914 Henry A. Taylor
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 11, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____,

and that death occurred on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:
Wm A. Bullet wound from the hand of Robert Taylor.
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John J. Cunningham, M.D.
Coroner
_____ 191____ (Address) Astoria, Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Union Cemetery DATE OF BURIAL July 14, 1914

20 UNDERTAKER C. J. Kraft ADDRESS Pikesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma. Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds. Never report *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc. When a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

AUG 6 1914

BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH **6631**
County **Baltimore Co.**

Village or City **Baltimore** (No. **64**, **Melvin** St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. **32**

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME **George M. Whitney**

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Male** 4 COLOR OR RACE **White** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED **Single**
(Write the word)

6 DATE OF BIRTH **6 29 1914**
(Month) (Day) (Year)

7 AGE **0 yrs. 0 mos. 12 ds.** If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) **Baltimore Co.**

10 NAME OF FATHER **George M. Whitney**

11 BIRTHPLACE OF FATHER (State or country) **N. Y.**

12 MAIDEN NAME OF MOTHER **Virginia L. Rose**

13 BIRTHPLACE OF MOTHER (State or country) **Md.**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Geo. M. Whitney**

(Address) **64 Melvin Ave.**

15 Filed **7/12 1914** **Henry A. Taylor**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **7 11 1914**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **July 11 1914** to **1914**, 191...
that I last saw him alive on ..., 191...

and that death occurred on the date stated above, at **2 P. m.**
The CAUSE OF DEATH* was as follows:

Fracture of skull failed to close

(Duration) **0 yrs. 0 mos. 12 ds.**
Contributory (Secondary) **Irregularity of circulation**

(Signed) **G. H. Beckley**, M. D.
July 11 1914 (Address) **Baltimore Md.**

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death **0 yrs. 0 mos. 12 ds.** to the State **0 yrs. 0 mos. 12 ds.**

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL **Landon Park Cem.** DATE OF BURIAL **July 13 1914**

20 UNDERTAKER **John C. Hughes** ADDRESS **142 E. Penna Ave.**

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name organ; "Oancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 6632

County Baltimore CoVillage or City Alherton (No. _____, _____ St.; _____ Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 31

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Stillborn child of Edw. & Myrtle Wiles

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Singl
(Write the word)

6 DATE OF BIRTH Born Dead, 1 (Year)
(Month) (Day)

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Edward Wiles

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Myrtle Sherman

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Wiles(Address) Alherton Baltimore County Md

15 Filed July 20, 1914 Alburt L. Rogers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____

that I last saw him alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still birth
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. N. Gorman, M. D.July 20, 1914 (Address) Bellevue City, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Alherton Md. E. County Howard Co. July 20, 1914

20 UNDERTAKER ADDRESS

Coastal Sons Bellevue City

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6633

County

Balto.

Village or City

near Alberton

(No.

St.

Ward)

Registration Dist. No.

31

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Edward Williams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

July 9, 1837
(Month) (Day) (Year)

7 AGE

77 yrs. x mos. x ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Pennsylvania

PARENTS

10 NAME OF FATHER

Edward Williams

11 BIRTHPLACE OF FATHER (State or country)

England

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (State or country)

Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emma B. Lilly

(Address)

Alberton

15

Filed

July 2, 1914 Alberton, Md.
S. H. Hunsinger, RegistrarSTATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 2, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 30th, 1914, to July 1st, 1914.

that I last saw him alive on July 1st, 1914.

and that death occurred on the date stated above, at 5-40 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of
antrum + basal jaw

(Duration) yrs. 5 mos. — ds.

Contributory
Secondary

(Duration) yrs. — mos. — ds.

(Signed)

A. C. L. Smith, M. D.

July 2nd, 1914. (Address) W. J. Smith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Chester Pa.

DATE OF BURIAL

July 5, 1914

20 UNDERTAKER

S. H. Hunsinger & Son

ADDRESS

Baltimore City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

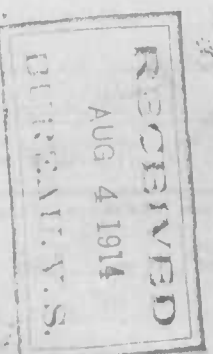
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1 PLACE OF DEATH **6634**
County Baltimore

Village or City Spomous Point (No. 706) St. 2 Ward 2

2 FULL NAME Mattie H Williams

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 44

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX fm 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH June 29th, 1914
(Month) (Day) (Year)

7 AGE 22 yrs. 22 mos. 22 ds. OR 22 min. ?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of Industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) none

10 NAME OF FATHER Philip Williams

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Florence Reed

13 BIRTHPLACE OF MOTHER (State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Philip Williams

(Address) Spomous Point

15 July 23, 1914 G. B. McComden M.D.
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 21st, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from July 15, 1914, to July 21, 1914.

that I last saw her alive on July 21, 1914.

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) 22 yrs. 22 mos. 22 ds.

Contributory Premature tooth 8
Secondary being one of twins

(Signed) G. B. McComden M.D., M. D.

July 23, 1914 (Address) Spomous Point

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 22 yrs. 22 mos. 22 ds. In the State 22 yrs. 22 mos. 22 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Spomous Point Cemetery DATE OF BURIAL July 23, 1914

20 UNDERTAKER Samuel Chase & Sons ADDRESS Balto.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | |
|--|---------------------------------|---|--|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 5635 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Spawns Point</u> (No. <u>708</u>) | | St. <u>C</u> | | Registration Dist. No. <u>44</u> | |
| 2 FULL NAME <u>James P. Wilson</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word) | | | |
| 6 DATE OF BIRTH <u>Nov. 9th</u> , 18 <u>84</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>69</u> yrs. <u>8</u> mos. <u>16</u> ds. If LESS than 1 day, hrs. OR min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Minister of the Gospel</u> (b) General nature of Industry, business, or establishment in which employed (or employer) <u>Preaching</u> | | | | | |
| 9 BIRTHPLACE (State or country) <u>Baltimore</u> | | | | | |
| PARENTS | | | | | |
| 10 NAME OF FATHER <u>Joseph Wilson</u> | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Baltimore</u> | | | | | |
| 12 MAIDEN NAME OF MOTHER <u>Sarah Van Sant</u> | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Penna</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Dr. Robert Wilson</u> (Address) <u>Spawns Point</u> | | | | | |
| 15 Filed <u>July 28th</u> , 191 <u>4</u> <u>G. C. McComick</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>July 27th</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>March</u> , 191 <u>4</u> , to <u>July 27th</u> , 191 <u>4</u> , that I last saw him alive on <u>July 27th</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>7:30</u> p. m. The CAUSE OF DEATH* was as follows: <u>Cancer of liver</u> (Duration) — yrs. <u>5</u> mos. ds. Contributory <u>Exhaustion</u> Secondary (Duration) yrs. mos. ds. (Signed) <u>G. C. McComick</u> , M. D. <u>July 27th</u> , 191 <u>4</u> (Address) <u>Spawns Point</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, It not at place of death? Former or usual residence..... | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Greenmount Cem.</u> DATE OF BURIAL <u>July 30</u> , 191 <u>4</u> | | | | | |
| 20 UNDERTAKER <u>John B. Spence</u> ADDRESS <u>Balto City</u> | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

6638

County

Baltimore

Village or City

Orangeville

(No.)

3904 Philadelphia Ave

St.:

Ward)

Registration Dist. No.

41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Melvin Everett Wilson

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|--------------------------|---|
| 3 SEX Male | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single |
| 6 DATE OF BIRTH November 30, 1913 (Month) (Day) (Year) | | |
| 7 AGE 7 yrs. 7 mos. 23 ds. | | If LESS than 1 day.....hrs. OR.....min. ? |

8 OCCUPATION
(a) Trade, profession, or particular kind of work.
(b) General nature of Industry, business, or establishment in which employed (or employer)
None

9 BIRTHPLACE
(State or country)
Md

| | |
|---------|---|
| PARENTS | 10 NAME OF FATHER Samuel E. Wilson |
| | 11 BIRTHPLACE OF FATHER (State or country) Md |
| | 12 MAIDEN NAME OF MOTHER Elizabeth Schaefer |
| | 13 BIRTHPLACE OF MOTHER (State or country) Md |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel E. Wilson

(Address)

3910 Philadelphia Ave

15

Filed

July 25, 1914

W. E. McClanahan

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 23, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1914, to July 23, 1914, that I last saw him alive on July 23, 1914, and that death occurred on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) yrs. 4 mos. 4 ds.

Contributory
Secondary

Enterocolitis

(Duration) yrs. 23 mos. 23 ds.

(Signed) Louis Vogel, M. D.
July 24, 1914 (Address) 2601 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.....

| | |
|---|---------------------------------|
| 19 PLACE OF BURIAL OR REMOVAL Mt Carmel Cemetery | DATE OF BURIAL July 25, 1914 |
| 20 UNDERTAKER Christian Miller | ADDRESS 2534 Jefferson |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

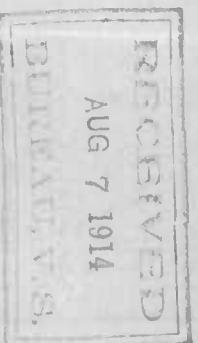
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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | |
|---|---|--|--|---|--|
| 1 PLACE OF DEATH County <u>Baltimore</u> | | 6637 | | STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>31</u> | |
| Village or City <u>Thos. Wilson</u> | | (No. <u>Mr. Wilson, Md.</u> St. <u>Ward</u>) | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>Albert Wokisky</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>S</u> | | | |
| 6 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year) | | | | | |
| 7 AGE yrs. <u>4</u> mos. ds. <u>OR</u> min. ? If LESS than 1 day, hrs. | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Baltimore</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Albert Wokisky</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Kane Jr</u> (Address) <u>Wt Wilson, Md.</u> | | | | | |
| 15 Filed <u>2</u> , 191 <u>4</u> | | | | | |
| REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>July 23rd, 1914</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>191</u> to <u>191</u> that I last saw him alive on <u>191</u> and that death occurred on the date stated above, at <u>m.</u> The CAUSE OF DEATH* was as follows: <u>marasmus</u> (Duration) <u>1</u> yrs. <u>1</u> mos. <u>0</u> ds. Contributory <u>Secondary</u> (Duration) <u>1</u> yrs. <u>1</u> mos. <u>0</u> ds. (Signed) <u>John Kane Jr</u> , M. D. <u>July 23, 1914</u> (Address) <u>Wt Wilson</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>10</u> yrs. <u>10</u> mos. <u>10</u> ds. In the State <u>10</u> yrs. <u>10</u> mos. <u>10</u> ds. Where was disease contracted, <u>at home</u> If not at place of death? <u>Baltimore</u> Former or usual residence <u>Baltimore</u> | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Unknown</u> DATE OF BURIAL <u>191</u> | | | | | |
| 20 UNDERTAKER <u>Unknown</u> ADDRESS <u>Unknown</u> | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

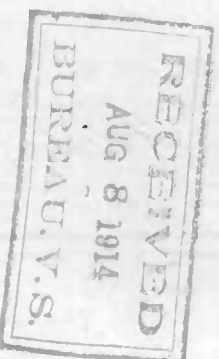
Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theuia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| PLACE OF DEATH | | | STATE OF MARYLAND | |
|---|---|--|---|------------|
| County | | | CERTIFICATE OF DEATH | |
| 6638 (89) | | | Registered No. 82 | |
| Village or City | | | (No.) | St.; Ward) |
| Annie I Wood | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| FULL NAME | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | | |
| Female | White | Widow | | |
| DATE OF BIRTH | | | | |
| Sept 22, 1872 (Month) (Day) (Year) | | | | |
| AGE | | | | |
| 41 yrs. 9 mos. 26 ds. If LESS than 1 day, hrs. OR min. ? | | | | |
| OCCUPATION | | | | |
| (a) Trade, profession, or particular kind of work | | | | |
| None | | | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) | | | | |
| none | | | | |
| BIRTHPLACE (State or country) | | | | |
| Prospect Va | | | | |
| PARENTS | NAME OF FATHER | | | |
| | Fugua | | | |
| | BIRTHPLACE OF FATHER (State or country) | | | |
| | unknown? | | | |
| MAIDEN NAME OF MOTHER | | | | |
| unknown | | | | |
| BIRTHPLACE OF MOTHER (State or country) | | | | |
| unknown | | | | |
| THE ABOVE TRUE TO THE BEST OF MY KNOWLEDGE | | | | |
| (Informant) Edmund D. Douch | | | | |
| (Address) Foulton Rd | | | | |
| DATE OF BIRTH | | | | |
| July 19, 1914 M. J. Port | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | |
| DATE OF DEATH | | | | |
| July 18, 1914 (Month) (Day) (Year) | | | | |
| I HEREBY CERTIFY, That I attended deceased from | | | | |
| July 9, 1914, to July 18, 1914 | | | | |
| that I last saw her alive on July 18, 1914 | | | | |
| and that death occurred on the date stated above, at 8:30 P. M. | | | | |
| The CAUSE OF DEATH* was as follows: | | | | |
| Exhaustion | | | | |
| Contributory (Secondary) | | | | |
| Infection, Delirium | | | | |
| (Duration) yrs. mos. 2 ds. | | | | |
| (Signed) Edmund D. Douch, M. D. | | | | |
| July 19, 1914 (Address) Foulton Rd | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | |
| LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | |
| At place of death yrs. mos. 9 ds. In the State yrs. mos. 9 ds. | | | | |
| Where was disease contracted, Norfolk Va | | | | |
| If not at place of death? | | | | |
| Former or usual residence Norfolk Va | | | | |
| PLACE OF BURIAL OR REMOVAL | | | | |
| Norfolk Va | | | | |
| DATE OF BURIAL | | | | |
| 729, 1914 | | | | |
| UNDERTAKER | | | | |
| Henry W. Jenkins | | | | |
| ADDRESS | | | | |
| 1014 Baltimore St. Balto | | | | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

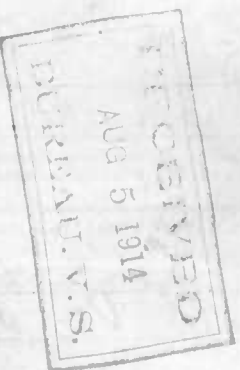
[Approved by U. S. Census and American Public Health
Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

6639

1 PLACE OF DEATH

County

Village or City

(No.)

Registration Dist. No.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
Secondary

(Signed)

, 191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

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[Approved by U. S. Census and American Public Health Association.]

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